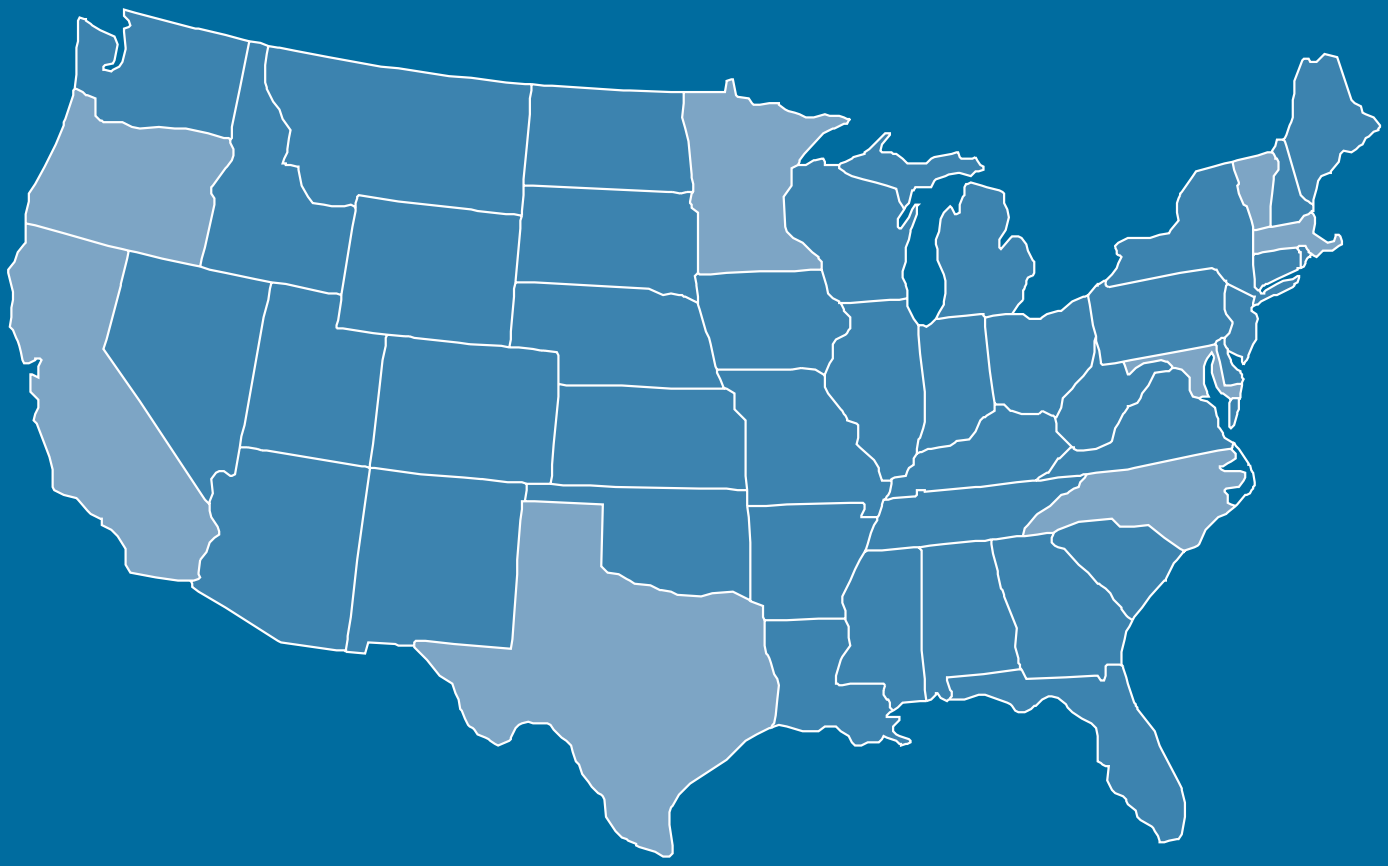
Financing Prevention

How States are Balancing Delivery System & Public Health Roles



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NATIONAL POLICY & LEGAL ANALYSIS NETWORK TO PREVENT CHILDHOOD OBESITY

NATIONAL ACADEMY for STATE HEALTH POLICY

ACKNOWLEDGMENTS

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ABOUT THIS REPORT

With significant opportunities to invest in public health and prevention, improve the health care delivery system, and increase access to services, the Patient Protection and Affordable Care Act (ACA) sets a backdrop for this report's exploration of efforts by eight leading states to support community-based prevention activities through delivery system and payment reform design and innovation. The report lays out the issues related to opportunities available to states to create a new balance in the financing of community-based interventions by capitalizing on health care delivery system mechanisms, the relevance for state policymakers and other interested stakeholders, and overviews of innovative state examples. It focuses specifically on state health policy and the role of state governments as conveners, regulators, policymakers, and purchasers.

The authors hope this report will be useful for state officials focused on public health, delivery system design and innovation, and chronic disease prevention and management, in addition to community stakeholders and local governmental leaders with an interest in community-based chronic disease prevention. Given the vast cultural and language barriers that separate many leaders in these fields, the authors have attempted to clearly define terms and provide context as needed, and have included links to follow-up information for those who are interested in learning more.

The report does not capture the full scope of the delivery system's efforts to improve population health, or the breadth of issues public health stakeholders address to improve social determinants of health. It focuses on the intersection of these two worlds, and the role of state leaders in maximizing resources and advancing collaboration to improve the health of the people they serve while striking a balance among the needs, interests, and resources available through health care providers, payers, public health departments, and community based organizations. The report emphasizes mechanisms to increase support for community-based interventions through delivery system mechanisms. Based on the disproportionate amount of U.S. health resources currently directed to the delivery system, some experts view this transition as a step toward striking a new balance.[1]

Many unexplored areas that deserve increased attention go beyond the scope of this report: inter-state regional collaborations or national groups addressing specific community-based issues; workforce and information technology issues related to changing roles in the health care delivery and public health systems; and private sector entrepreneurship.

Research Methods

The authors conducted an environmental scan of the ACA, delivery system financing mechanisms, population health initiatives, and existing linkages between the delivery system and community-based population health. Information sources included peer-reviewed articles, research reports, state and federal government websites, and PowerPoint presentations developed by recognized leaders in the fields of population health and delivery system transformation. Although several publications discuss delivery system and public health stakeholders collaborating to improve population health, and some focus specifically on financing mechanisms, the authors found no publication that explicitly focuses on the role of states in striking a balance between systems.[2]

Through the environmental scan, authors identified eight states to be profiled in this report. These states have a history of delivery system transformation, programs that encourage linkages between community partners and the delivery system, and statewide strategies for population health improvement. For each state, we gathered background information on their programs, focusing particularly on funding sources,

explicit goals for childhood obesity and other chronic disease prevention and management, and linkages between the delivery system and community-based population health strategies. Of the states in the scan, eight were selected as leaders with unique models to be profiled.

Following the environmental scan, the authors conducted interviews with state health officials from these eight states to tease out the delivery system's role in supporting community-based prevention and exploring application to childhood obesity in their states. The authors chose to explore childhood obesity because it has evidence-based clinical and community public health interventions and is a priority area for the Robert Wood Johnson Foundation, the project's funder. Interviewees represented a range of state agencies (e.g. Medicaid, public health, broader umbrella agencies), focusing particularly on the agencies with responsibility for the funding opportunity of interest. The purpose of the interviews was to gather information on the states' models, as well as to understand the states' successes, challenges, lessons learned, and next steps. In addition, interviewees were asked to share their perspective, as delivery system or public health experts, on the delivery system's role in supporting community-based prevention. Interviewees and several other experts were given an opportunity to review and provide feedback on the report prior to its publication.

The appendix provides in-depth profiles of each featured state.

GLOSSARY OF TERMS

Accountable Care Community
A broadened concept of accountable care organizations (see below) that includes other entities, such as community-based organizations, local health departments, or social service providers, in addition to health care providers, in the group held accountable for performance.

Accountable Care Organization
A model of care that distributes accountability for performance on cost and quality metrics across groups of health care providers, tying shared savings and other financial rewards to maintenance or improvement of care quality.

Community-Based Prevention/Community-Based Interventions/Community-Based Programs
For the purposes of this report, these terms are used interchangeably to refer to programs or policies within a community that seek to improve the health of a population by addressing non-medical factors, or social determinants of health. Such programs often include the application of non-clinical preventive methods in non-traditional health care settings by non-clinical providers.

Community Benefit Requirements
Federal Internal Revenue Service requirements that non-profit hospitals must meet to maintain their non-profit status.

Community Health Needs Assessment
An evaluation of the health needs of a community that the Affordable Care Act (ACA) requires hospitals to perform as part of their community benefit requirements. Hospitals must seek input from community members, particularly those with expertise in public health. Per the ACA and subsequent regulatory guidance, failure to conduct a community health needs assessment may result in a $50,000 penalty and loss of a hospital's non-profit status.[3]

Community Health Teams
Interdisciplinary teams of service providers (which may include both clinical and non-clinical providers) who coordinate care across community organizations for patients with complex conditions.

Fee-for-Service
Payment model in which health care providers are reimbursed separately for each service provided.

Health Care Delivery System
Refers to the clinical system that pays for and delivers health care services to individual patients.

Managed Care
A system of health care in which patients seek services from certain providers selected by a managing organization, such as an insurance company, in an effort to control costs and improve quality.

Medicaid Waivers
Mechanism used by the federal government to provide states with greater flexibility in the design of their Medicaid programs.

Multi-Payer Initiatives
Programs that are supported by payments from multiple entities, which may include both public and private health care insurers.

Patient-Centered Medical Home (PCMH)
A delivery system model designed to provide team-based, coordinated care in which providers often receive payment enhancements when performance expectations are met.

Population Health
For the purposes of this report, population health is defined as "the health outcomes of a group of individuals, including the distribution of such outcomes within the group" (Kindig and Stoddart 2003).[4]

Primary Prevention
Efforts to prevent disease from occurring.

Return On Investment (ROI)
A term used to calculate the benefit of an investment. For purposes of this report ROI is used to measure the costs and savings that could result from investing in community-based interventions, where positive ROI indicates a net savings.

Secondary Prevention
Interventions used to slow or halt the progress of an existing disease.

Social Determinants of Health
The social and economic factors that impact the health of an individual or a group of individuals.

State Innovation Models (SIM)
A Center for Medicare & Medicaid Innovation (CMMI) program that awards grants to states to support multi-payer (including public and private insurer participation) health system transformation efforts.

Triple Aim
A term used to describe an approach for enhancing health system performance. The goals of the Triple Aim, as conceptualized by the Institute for Healthcare Improvement are: improve the patient experience of care, improve the health of populations, and reduce the per capita cost of health care (Berwick et al. 2008).[5]

EXECUTIVE SUMMARY

The Patient Protection and Affordable Care Act (ACA) sets bold goals for the United States' health care system by placing a collective focus on the "Triple Aim": improving individual patient care, improving population health, and reducing health care spending. Along with increasing access to health insurance coverage, the ACA introduced significant opportunities to reform the health care delivery system. The ACA makes a significant investment in public health and prevention, placing special emphasis on prevention through both the public health and delivery systems. The ACA uses traditional funding mechanisms, such as federal grants, to invest additional dollars in the country's public health infrastructure and community-based prevention. The law also creates the potential for more sustainable funding for community-based prevention programs by emphasizing population health outcomes in delivery system reform initiatives.[6]

Many of the ACA's opportunities and investments are directed at states, reaffirming each state's critical role in reforming the country's health and health care systems. Both states and the federal government are working together to build and test new models of health care delivery with goals that include improving population health and bending the cost curve, and require intervention at the community level to be effective. The current system is complex and fragmented with subsystems operating in silos. These new models require the creation of new partnerships across state and local government agencies, communities, and private sector stakeholders.

The authors identified and interviewed eight states for this report (California, Maryland, Massachusetts, Minnesota, North Carolina, Oregon, Texas, and Vermont). These states have combined many of the new policy levers and resources offered through the ACA with existing state authority in order to create a new balance between the health care delivery and public health systems with the ultimate goal of improving care, improving health outcomes, and reducing costs. This report identified six mechanisms these states are using to evolve their respective delivery systems to support community-based interventions. They fall into three categories:

- Existing federal authority and grants (e.g. Medicaid waivers and State Innovation Model (SIM) grants);
- Delivery system reform models (e.g. accountable care, medical homes, pooled funding); and,
- New federal requirements for non-profit hospitals (community benefit).

Several common lessons become apparent, based on the experiences of the eight states profiled in this report. These lessons may be helpful to other states and stakeholders as they seek to identify new and emerging opportunities for supporting community-based initiatives through delivery system mechanisms. The lessons fall into two major categories: "collaboration and communication" and "financing and sustainability."

Collaboration & Communication

- State government is in a unique position to convene broad groups of stakeholders to achieve a common goal of improved health.
- To collaborate productively, stakeholders must have clearly defined roles that leverage their expertise and capacity.
- State-level actions can pave the way for breaking down siloes at the local level.
- States can require or incentivize community-level partnerships to encourage ongoing sustainable collaboration across sectors.

Financing & Sustainability

- State initiatives must demonstrate a business case for delivery system stakeholders to invest in community-based prevention.
- State initiatives may need to target secondary prevention for early financial wins, with the goal of moving to primary prevention as a next phase.
- The prospect of sustainable funding can motivate public health entities to partner with the delivery system.

It is difficult both for the public health and delivery systems to do things differently. States can take advantage of the opportunities offered by the ACA to build stronger partnerships across the public health and health care delivery systems to support community-based interventions. In doing so, states can build on previous innovations to make synergistic, transformative changes to both the public health and delivery systems to improve population health.

AN OVERVIEW: PUBLIC HEALTH, DELIVERY SYSTEM REFORM, & THE AFFORDABLE CARE ACT

The Current State of Health Care Delivery & Public Health Systems

The United States health care system is complex and fragmented, comprised of multiple services and subsystems that often do not interact to best meet the needs of individuals, let alone populations. Historically, there have been two mostly separate systems for supporting and improving health: health care delivery and public health.

The health care delivery system is comprised of individual and institutional providers of health care services, as well as the private and public insurance plans that finance these services. The delivery system focuses primarily on improving the health of patients through clinical medical interventions. There is broad recognition of serious problems within the delivery system, particularly in the areas of access, quality and costs. As the Institute of Medicine stated in 2001, "The nation's current health care system often lacks the environment, the processes, and the capabilities needed to ensure that services are safe, effective, patient-centered, timely, efficient, and equitable."[7] Moreover, the delivery system has historically treated disease after it has occurred.

The public health system includes state and local public health departments and other governmental and non-governmental entities that place emphasis on community and population health, rather than the individual. The public health system predominantly works outside the clinical setting to prevent injury or disease by taking into account factors, such as socioeconomic status, environmental conditions, and behavioral choices, which also influence health.[8] This system also faces significant challenges, particularly in the area of financing. Traditionally, public health activities have been funded through local or state tax dollars, federal formulas for allocating funding across states, and competitive federal and foundation grants. This haphazard financing structure makes it difficult to sustain public health initiatives, including community-based interventions. In addition, public health initiatives have historically focused on preventing a single disease or health condition, meaning that efforts and funding have not been aligned across multiple initiatives, often working at cross purposes.

The fragmentation within both systems, and the lack of coordination between the two, has resulted in an imbalance of high health spending and poor health outcomes. In 2012, health expenditures accounted for 17.2 percent of the United States' gross domestic product.[9] Compared to other industrialized nations, the United States spends two-and-a-half times more per person on health care.[10] At the same time, the United States ranks below other industrialized nations in health status, ranking 26th in life expectancy among Organisation for Economic Co-operation and Development (OECD) nations in 2011.[11] Seminal studies have shown that about half of all deaths in the United States are due to preventable (behavioral and exposure) factors, and that health status is most influenced outside the clinical setting.[12] Yet of the $2.8 trillion invested in health in 2012, 85 percent went to personal health care spending including hospital and physician services, and prescription drugs.[13]

The Role of Community-Based Interventions in Preventing Chronic Disease

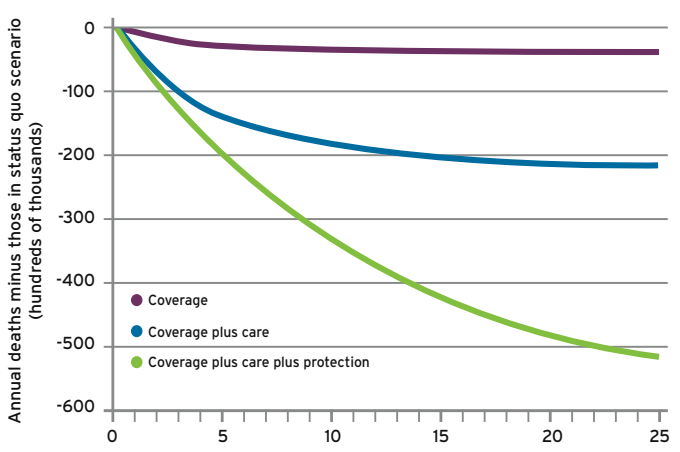
In a nation where chronic diseases are now the top cause of morbidity and mortality, and much of this disease burden is due to preventable causes,[14] "it is no longer sufficient to expect that reforms to the medical care delivery system (for example, changes in payment, access and quality) alone will improve the public's health."[15] Increasing evidence indicates that community-based interventions can be effective at changing behaviors, preventing disease and reducing health care costs.[16]

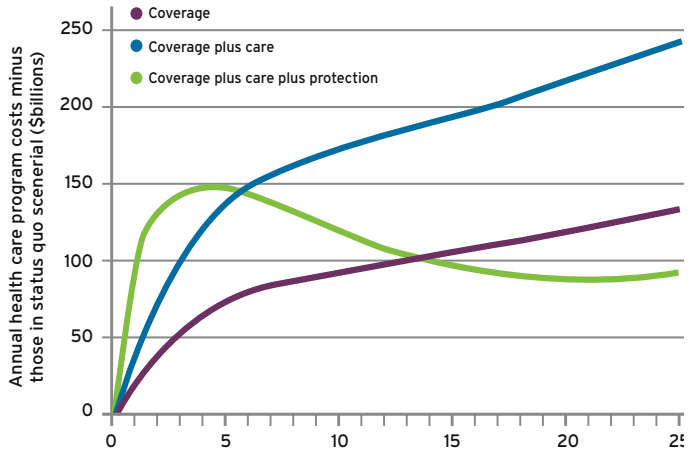
Community-based interventions may include programs that apply preventive methods in non-traditional health care settings by non-traditional providers, as well as policy changes at the community level that promote health and wellness. Community-based interventions can address the behavioral, environmental, and social determinants of health.[17]

Research from Trust for America's Health suggests that within five years, nationwide investment in evidence-based community prevention programs could yield a savings of $5.60 for every $1 spent.[18] One 2011 study, shown in Figures 1 and 2, found that by including population health strategies to prevent disease, along with improved access to coverage and care, the U.S. health system has the potential of saving 90 percent more lives and reducing costs by 30 percent within a 10-year period. Even greater benefits are achieved when looking across a 25-year period — a 62 percent reduction in costs and 140 percent more lives would be saved.[19]

FIGURES 1 AND 2

ANNUAL DEATHS AND ANNUAL COSTS OVER TIME FOR COVERAGE, COVERAGE PLUS CARE, AND COVERAGE PLUS CARE PLUS PROTECTION





Source: Copyrighted and published by Project HOPE/*Health Affairs* as Exhibit 2. Milstein B, Homer J, Briss P, Burton D, Pechacek T. *Why behavioral and environmental interventions are needed to improve health at lower cost.* Health Aff (Millwood). 2011 May;30(5): 823-832. The published article is archived and available online at *www.healthaffairs.org*.

Notes: Results are from the model's baseline setting.

Obesity provides an illustrative example of the potential collaborative roles that the health care delivery system, public health system, and community-based interventions can play in reducing chronic disease, improving health and reducing costs. It is estimated that by 2030, obesity-related medical costs could rise by $48 to $68 billion per year in the United States[20] and currently one-third of the nation's children between the ages of 2 and 19 are obese.[21] The OECD predicts that by 2020, 75 percent of Americans will be overweight or obese.[22] In addition, the OECD estimates that obesity amounts to five to ten percent of the total health care costs in the United States.[23] Overweight and obese children are at risk for becoming overweight or obese adults, particularly if a child is overweight or obese during his/her teenage years.[24,25] Obese children and adolescents are at increased risk for developing type 2 diabetes and other chronic conditions, such as cardiovascular diseases and cancer, as adults.[26]

Collaboration between the health care delivery and public health systems can enable communities to leverage all of their relevant assets to improve obesity-related health outcomes using the following types of interventions:

- A program that provides intensive in-home support to at-risk families using community health workers (CHW), funded by the state's Medicaid program;
- An accessible, multi-lingual community education campaign about how to prevent diabetes;
- Alignment of local government and health care system institutional policies to reduce the sale of sugar-sweetened beverages; and,
- Evaluation of health care delivery cost savings per patient, the health profile of the patient population, and community-based population measures.

In order to encourage this kind of collaboration, states and communities must leverage the various funding mechanisms described in this paper to create financial incentives for collaboration to improve health outcomes.

The Affordable Care Act: Leveraging New Opportunities

The ACA, passed in 2010, marked a turning point for the country's health care system. Along with increasing access to health insurance coverage, the ACA introduced significant opportunities to reform the health care delivery system and invest in public health and prevention. Notably, many of the ACA's opportunities and investments are directed at states, reaffirming their critical roles in working with the federal government to reform the country's coverage, delivery and public health systems.

Prior to the ACA, states already felt the pressure to hold the delivery system accountable for improving quality and patient outcomes, while reducing costs. Some states and localities began to develop small-scale community-based chronic disease prevention and management strategies towards this goal. The ACA gives states new policy levers and resources, as described in Table 1, to further amplify these opportunities and implement these strategies on a broader scale. On the public health side, the ACA uses traditional funding mechanisms, such as federal grants, to invest additional dollars in the country's public health infrastructure, placing a much stronger federal emphasis on community-based chronic disease prevention and management than existed previously. The ACA also makes investments in identifying the evidence base for effective community-based strategies, which can help states target their investments more wisely.

The ACA also creates the potential for more sustainable financing structures for community-based intervention, described in this report. The ACA gives states funding for community-based supports, such as community health workers, community health teams, home visiting programs and school-based health centers. In addition, the ACA gives flexibility in the way states pay for health care, allowing states to place emphasis on prevention and community resources in delivery system design. For example, state Medicaid programs now have more straightforward mechanisms and incentives to pay for non-traditional services like care coordination and referral to community support services for high-risk beneficiaries with chronic disease. States also now have flexibility and funding to design new payment methodologies that can create incentives for prevention and community-based interventions.

As the health care delivery and public health systems adjust to a new reality, there is expanded opportunity for states to make synergistic, transformative changes to both systems as the systems are redesigned with support of resources and new policy levers made available through the ACA. For example, the Centers for Disease Control and Prevention's (CDC) Coordinated Chronic Disease Prevention and

Health Promotion program, created by the ACA, gives state public health departments grants to develop overarching chronic disease prevention strategies which must include "engagement with health care systems" and "enhancement of clinic-community linkages."[27] In terms of the delivery system, the Centers for Medicare and Medicaid Services' (CMS) State Innovation Models (SIM) program, also created with ACA funding, encourages state delivery system planners to "integrate community health and community prevention activities in their multi-payer models" for payment reform efforts.[28]

Although challenges exist in both the public health and delivery system sectors to break away from traditional ways of thinking and acting, states can take advantage of the opportunities offered in the ACA to build better partnerships across the public health and health care delivery system, and to incorporate community-based interventions in an effort to prevent chronic diseases. The ACA drives changes for both systems toward bold common goals by placing a collective focus on the "Triple Aim:" improving individual patient care, improving population health, and reducing health care spending. [29] Many of the initiatives are built to encourage linkages across the health care delivery system and public health sector, to align work and achieve the Triple Aim.

TABLE 1
EXAMPLES OF ACA PROVISIONS THAT OFFER AN OPPORTUNITY FOR STATES TO FOSTER GREATER DELIVERY SYSTEM AND PUBLIC HEALTH COLLABORATION IN COMMUNITY-BASED PREVENTION[30]

Opportunity for new delivery system-public health balance	Examples of ACA provisions that create this opportunity (Summary of § section of ACA)
Grants to local, community and/or state entities to promote chronic disease prevention and management	Childhood obesity demonstration project (*§4306*) Prevention and Public Health Fund programs including *Communities Putting Prevention to Work* program (phase two), *Healthy Living Innovation Awards* program (*§4002*)
Grants to states to develop public health transformation strategies	Prevention and Public Health Fund programs including *Community Transformation Grants, National Public Health Improvement Initiative,* and *Statewide Coordinated Chronic Disease Prevention and Health Promotion Program* (*§4002*)
Research to increase evidence base for chronic disease prevention and management	Evaluation of community based prevention and wellness programs in Medicare (*§4202*) *Patient Centered Outcomes Research Institute* (*§6301*)
Requirement for hospitals to assess community needs	*Community Health Needs Assessment requirement* (*§9007*)
Increased data reporting and data sharing to enable population-level data sets	Creation of *standard measures* for acute, chronic, primary and preventive care (*§3013*) *Physician Quality Reporting System* requirements (*§3002*)
Funding for developing and improving community-based settings for health care	*School based health centers* (*§4101*) *Home visiting* (*§2951*) Community Health Center Fund (*§10503*)
Grants to states to support non-traditional health care providers	Community Health Teams (*§3502 modified by §10321*) Community Health Workers (*§5313*)
Support for primary care providers to improve in their practices	*Primary Care Extension Program* (*§5405*)
New options to pay for non-traditional services in Medicaid	Option to provide coordinated care through a *health home for Medicaid beneficiaries with chronic conditions* (*§2703*) *Incentives for prevention of chronic disease* (*§4108*)
Increased flexibility for states in structuring payments to health care providers in Medicaid	*Center for Medicare and Medicaid Innovation initiatives (including State Innovation Models* (SIM)) (*§3021*) Medicaid demonstrations to test bundled payments, global capitated payments, and pediatric accountable care organizations (*§2705*, *§2706* and *§3023, as modified by §10308*)

MECHANISMS TO ALIGN THE DELIVERY SYSTEM & COMMUNITY-BASED PREVENTION

The states profiled in this report (California, Maryland, Massachusetts, Minnesota, North Carolina, Oregon, Texas, Vermont) have taken full advantage of the opportunities made available by the ACA to support community-based prevention through delivery system mechanisms. They have combined many of the new policy levers and resources offered through the ACA with existing state authority to create a new balance between the health care delivery and public health systems. This section describes in depth six of the mechanisms states are employing. As Table 2 demonstrates, comprehensive state strategies can incorporate many of these mechanisms to motivate and support delivery system stakeholders as they move into the realm of community-based initiatives.

Medicaid Waivers

As the joint federal-state program that finances health care for eligible low-income people, Medicaid includes important policy levers that states can use to drive change in the health care system. Although states can make many choices and have options to define the structure of their Medicaid programs, the Medicaid waiver is a mechanism that the federal government uses to provide states with even more flexibility in Medicaid design. All of the states profiled in this report use or have used waivers to support community-based interventions as part of their delivery system and payment innovations.[31] There are four primary waivers and demonstration authorities; each granting states a different type of flexibility.[32] The most common waiver used for large-scale transformation efforts is referred to as a "Section 1115 waiver." This "research and demonstration" waiver allows states to adjust their Medicaid program's eligibility and coverage of services, outside the conventional Medicaid structure, in addition to testing delivery system innovations. Waivers can also allow states to spend Medicaid funds outside the traditional fee-for-service payment model. Typically, a Section 1115 waiver is granted to a state for a period of five years. After the demonstration period, the federal government may extend the waiver or the state may seek to continue to support the demonstration through a long-term sustainable funding model.

Despite being limited to projects supporting the Medicaid and Children's Health Insurance Program (CHIP) beneficiaries, Medicaid waivers have several key benefits for states that allow them to reach beyond this limitation. First, Medicaid is funded by both state dollars and by federal matching funds that are at least equal to the amount of state funds, and in some cases much higher.[33] The federal match and flexibility of the program enhances states' ability to test and invest in delivery system innovations, such as paying for services delivered by non-traditional Medicaid providers, e.g. community health workers, and for services delivered outside of clinical settings, as in schools.[34]

A Medicaid or 1115 waiver is an important policy lever for states to drive community-based interventions in delivery system design that could have a ripple effect on health care providers and the insurance market. As one state official interviewed for this report said, an 1115 waiver can be "a tremendous opportunity to do things you haven't done otherwise." For example, rather than strictly using Medicaid funds to reimburse for health care services, the Texas waiver creates a pool of funding to which hospitals and other providers can apply to receive financial support for improvement and prevention projects (see the Texas profile for further description). In Oregon, the 1115 demonstration waiver allows the state to give Coordinated Care Organizations (see the profile of Oregon for further description) a flat amount or "global budget" to cover health care services and community health improvement expenses.

Medical Homes & Neighborhoods

Primary care is the foundation of the health care delivery system. Since 2007, states and the federal government have increasingly gained interest in the patient-centered medical home (PCMH) model, which seeks to improve the coordination of the delivery of health care services for patients.[35] More broadly, "medical neighborhoods" build out a network of specialty and acute health care providers, and community resources, to work with the primary care PCMH.[36] Some PCMH models also make use of community health teams, which include non-traditional providers (such as social workers, care managers, and health coaches) who coordinate care across community organizations for patients with complex conditions.[37]

The PCMH model's financing component allows for primary care practices, certified as PCMHs by either state or national accreditation agencies, to receive an additional payment from Medicaid, commercial payers, or some combination of payers that goes above and beyond a traditional fee-for-service payment.[38] This additional payment allows PCMHs to perform functions like chronic disease management and prevention, care coordination, and health promotion, which are not typically incentivized in a fee-for-service payment structure. States and insurers often provide technical assistance such as quality improvement support and care management tools to help primary care practices succeed as PCMHs.[39]

Of the states profiled, Maryland, Massachusetts, Minnesota, North Carolina, Oregon, and Vermont all have multi-payer PCMH initiatives underway, and Minnesota, North Carolina, and Vermont make use of a community health team model.[40]

Accountable Care

Broadly, an accountable care arrangement is one in which a health care provider or other entity keeps the financial savings they generate from better-than-expected health care performance, while being held accountable for certain quality and outcomes standards. Programs vary in the type of entity held accountable, in the methodology they use to determine what constitutes "savings," and in the metrics used to gauge quality and outcomes. Across these arrangements, the major opportunity lies in holding delivery system players financially responsible for their patients' health outcomes. Since strategies that prevent and manage chronic diseases and employ community-based interventions are often more cost-effective than acute medical treatment, accountable care can be designed to incent providers to use these tactics.

Although many entities, including states, the private sector, and the federal government have driven existing accountable care arrangements, states have the special ability through their convening, regulatory, and purchasing powers to align financial incentives across payers and providers, and increase the impact of accountable care.[41] Recently, several states have been able to push the bounds of accountable care, experimenting with different ways to divide accountability across community partners, sometimes known as "Accountable Care Communities." This arrangement promotes the notion of shared responsibility across a partnership of entities, including health care providers and community-based organizations, rather than holding a single entity responsible for health care and health improvement. As one interviewee said, the goal is "trying to foster a sense of shared accountability for a defined population." Of the states interviewed for this report, Oregon, Minnesota, and Vermont are requiring that organizations participating in an accountable care arrangement enter into community partnerships.

The challenge of a shared responsibility arrangement is that no entity may ultimately be held responsible for failing to achieve agreed-upon results. States are testing various ways to formalize partnerships (e.g. through memorandums of understanding (MOUs), contracts, or with financial incentives) to ensure partners' commitments. In addition, states are developing statistical methodology to attribute health improvements to different partners and to divide up financial savings and rewards fairly among partners.

Some interviewees noted that accountable care arrangements might be particularly well suited for motivating providers and partners to improve population health in areas where there is a defined community, such as in rural areas. In such cases, the population for which an entity is accountable is clear, and the public health and delivery systems both serve the same population. In urban and suburban areas, where the overlap between primary care and hospital service areas and county lines tend to be less tight, the health care system and public health system may see themselves as accountable for very different populations.[42] States are working on different approaches to define populations and overcome this challenge.

Pool or Fund Created From a Delivery System Source

Similar to the grant structure for traditional public health activities, states can establish a pool or fund of delivery system dollars to support community-based population health improvement and community-clinical collaborations. For example, Massachusetts assesses a percentage of insurance and hospital revenue into its Prevention and Wellness Trust Fund. In a more complex arrangement, Texas' Medicaid waiver is structured so that hospitals and other public entities contribute local public funds for a pool, which is further enriched by the federal Medicaid match. The examples suggest that using delivery system sources to establish a pool or fund, rather than relying on a state's general fund appropriation process or federal grant dollars that are frequently subject to change, can create a more stable source of funding for community interventions. In addition, states can fund delivery system partners who contribute funding to these pools or funds to encourage greater collaboration in community-based interventions.

State Innovation Models (SIM) Initiative

Established by the ACA within the Centers for Medicare and Medicaid Services (CMS), the "Innovation Center" was created to test "innovative payment and service delivery models to reduce program expenditures" within government health care programs.[43] The State Innovation Models (SIM) initiative is a signature Innovation Center program that awards grants to states to support multi-payer (including Medicaid and commercial insurer participation) health system transformation efforts. The SIM program has given states the resources, framework, and new ideas to connect existing initiatives into an overarching, ambitious strategy for health reform, to improve health outcomes for the state's population. In February 2013, 26 states received SIM awards, totaling $300 million.[44]

There are two types of SIM awards, "testing" and "design." A SIM "model testing" award provides states with funding to implement statewide multi-payer health system transformation. The first model testing awards were given to states that had a history of significant reforms and were prepared to implement comprehensive strategies. Other states may apply for the second round of funding in 2014. Four of the states interviewed for this report — Massachusetts, Minnesota, Oregon and Vermont — received a model testing award averaging $45 million per state over a 42-month period.

A SIM "model design" award provided funding for states that did not already have a transformation strategy to develop their own State Health Care Innovation Plan. A State Health Care Innovation Plan "is a proposal that describes a state's strategy…to transform its health care delivery system through multi-payer payment reform and other state-led initiatives."[45] States can apply for the second round of model testing awards to implement their plans, although they are not guaranteed additional funding. Of the states interviewed for this report, three — California, Maryland, and Texas — received a model design award for between $2 and $3 million each.

New Community Benefit Requirements for Non-Profit Hospitals

In order for non-profit hospitals to maintain their non-profit status, they must comply with the federal "community benefit" standards as required by the Internal Revenue Service since 1969. The ACA revised the federal standards by requiring non-profit hospitals to, among other requirements, conduct a community health needs assessment and develop an implementation strategy once every three years. Hospitals must seek out input from community members, particularly those with expertise in public health. Per the ACA and subsequent regulatory guidance, failure to conduct a community health needs assessment may result in a $50,000 penalty and loss of a hospital's non-profit status.[46] In addition, non-profit hospitals must comply with state community benefit requirements.

Several states see the new federal community benefit requirement as a huge opportunity for encouraging hospitals to participate in community-based health improvement. As of 2011, two-thirds of states had over 50 percent of their hospitals classified as non-profit, making the requirement a significant policy lever.[47] The key, according to interviewees, is linking hospitals with existing expertise in community health improvement. States that have previously attempted to impose similar requirements on hospitals have found that hospitals may not have the expertise in community health improvement strategies, and may not realize they can draw on the resources already available in the community through local health departments. Since hospitals are now federally required to undertake community-based interventions, state public health and Medicaid programs can take steps to align these interventions with existing expertise and initiatives already underway in their communities. For example, Oregon requires its Coordinated Care Organizations to conduct community risk assessments and create plans for improvement. To make the process easier for hospitals and motivate them to participate in creating an aligned community-wide health improvement strategy, the state will align its requirements with the federal community-benefit requirement hospitals already face, so that hospitals can participate in one process to meet both standards.

Table 2 provides an overview of the various mechanisms underway in the states profiled in this report, demonstrating how leading states weave these innovative tools together to drive change to support community-based interventions.

TABLE 2
STATES' USE OF INNOVATIVE DELIVERY SYSTEM MECHANISMS TO SUPPORT COMMUNITY-BASED INTERVENTIONS

State	Medicaid waiver supporting delivery system innovation	Medical homes and neighbor-hoods	Accountable care	Pool or fund created from delivery system source	State Innovation Model (SIM) grant award	Leveraging community benefit requirements
California[1]		X	X	X	Design	
Maryland		X	X		Design	X
Massachusetts[2]	X	X	X	X	Testing	
Minnesota		X	X		Testing	X
North Carolina		X				
Oregon	X	X	X	X	Testing	X
Texas[3]	X	X		X	Design	X
Vermont	X	X	X		Testing	

Table Notes: Unless otherwise noted a state's mechanism refers to its comprehensive transformation strategy.
[1] California's mechanism refers only to the state's Accountable Care Communities model.
[2] Massachusetts' mechanisms refer only to the state's Prevention and Wellness Trust fund.
[3] Texas' mechanisms refer only to the state's Delivery System Reform Incentive Pool. Patient- Centered Medical Homes are one of the DSRIP project options.

LESSONS FROM LEADING STATES' EXPERIENCES

The eight states profiled in this report share several common lessons based on their experiences. These lessons may be helpful as other states and stakeholders seek to identify new and emerging opportunities for supporting community-based initiatives through delivery system mechanisms. The lessons captured in this section fall into two major categories: "collaboration and communication" and "financing and sustainability."

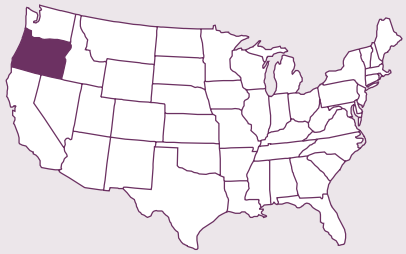
Collaboration & Communication

- **State government is in a unique position to convene broad groups of stakeholders to achieve a common goal of improved health**.

  With roles and responsibilities for both delivery system and public health functions, and policy and financial levers that impact both systems, state leaders are in a unique position to engage stakeholders to build buy-in for the overarching goals of transformation. Although several state officials interviewed for this report acknowledged including many groups in a planning process becomes complicated, they view it as essential. These stakeholder engagements include workgroups that make recommendations to the state, public meetings, opportunities for public comment, one-on-one meetings with state staff, and statewide stakeholder summits. As they facilitate these meetings, state agencies can work with stakeholders to define common terminology, helping to translate across jargon and vernacular used in various programs.

  Through stakeholder meetings, state agencies can help partners identify and build support for a shared goal, such as "making [the state] the healthiest state in the nation" or "achieving the triple aim." Involvement in the process gives all stakeholders ownership of the goal. As one state official explained about the importance of incorporating stakeholder input, "If you can identify things they [stakeholders] want, to overlap with what you want to get done, that's proven successful." In addition to building buy-in for a plan, having a shared goal increases alignment across partners' initiatives, orienting work toward a common desired outcome, and enabling initiatives to be mutually supportive.

  States also use their convening power to establish statewide learning collaboratives that assist in the spread of successes and best practices around the state, give local partners an opportunity to get advice from experts, and strengthen relationships between partners who participate in the collaborative together.



State Example
OREGON'S LEARNING COLLABORATIVES

Oregon has set up several learning collaboratives for providers, health plans, and community partners participating in its Coordinated Care Organizations through its new Transformation Center. Currently, the Center holds monthly sessions focused on sharing best practices and challenges in one of 17 areas for which community partnerships are held accountable. Recent and upcoming topics include high utilizers and complex care management, early access to prenatal care, and screening and follow up for clinical depression.[48]

- **To collaborate productively, stakeholders must have clearly defined roles that leverage their expertise and capacity.**

  Many interviewees noted that the prospect of shifting roles is worrisome for professionals in both the public health and the delivery systems. Some interviewees described concerns among local public health personnel about losing their traditional programs and working in imbalanced partnerships with powerful health care system stakeholders. Interviewees also heard concerns from health care providers about diverting attention from their core mission of patient care and redirecting funding to community-based organizations. Bringing the two sectors together is seen as a threat to business as usual from both perspectives.

  Interviewees noted that a more concrete project with a clear scope increases partners' willingness to divide up responsibilities and make assignments according to which entities have the greatest expertise and capacity. One state official explained, "we've found it's helpful to identify what people think is within locus of their control and what they can provide and then broaden it out." For example, in a tobacco

prevention project, a health care provider may ask patients whether they smoke, referring them to a tobacco cessation program and pulling population-level reports out of their electronic health record system. In turn, the public health entity could provide tobacco cessation counseling and implement a tobacco prevention program in a particular neighborhood school. Thus the partnership improves the referral process, targets community initiatives to real needs, and allows for greater evaluation of all partners' impact.

- **State-level actions can pave the way for breaking down siloes at the local level.**

  Collaboration among state agencies can provide the leadership and model for local-level agencies to break down their own siloes. For example, states can align reporting requirements across agencies, or develop common funding streams accessible to a community partnership of delivery system and public health entities. This helps overcome barriers that partners may face at the local level if they are held accountable to different outcomes and funded in different ways, and also sets an example for collaboration across agencies.

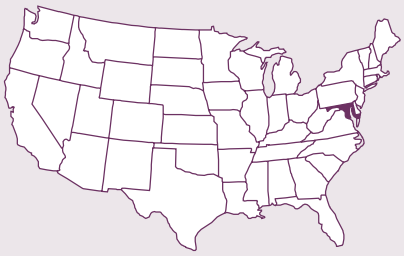
  States also can use their leverage with the federal government to help local entities with federally funded projects align with common community transformation goals. For example, some states are working directly with federal agencies such as the CDC to determine ways federal funding streams can be better aligned with state transformation initiatives. As one state official described it, the big outstanding question guiding this work is "How do you blend funding streams so they are most effectively used on the community level?"

- **States can require or incentivize community-level partnerships to encourage ongoing sustainable collaboration across sectors.**

  Many of the states profiled in this report have found that suggesting or requiring delivery system and public health stakeholders to form partnerships for community health improvement can help ensure that collaboration across sectors continues, once an initiative moves from planning to implementation. Oregon, Texas, and Maryland all require community partnerships for participation in their respective transformation models. Other states encourage partnerships, such as Massachusetts, which expects delivery system and community entities to apply jointly for grants from its Prevention and Wellness Trust Fund.

  A few states noted that formalizing partnerships through a MOU or contract can help in a situation in which no single entity is solely responsible for improvement. It also helps overcome cultural differences, in which an organization accustomed to having control and responsibility over its initiatives must share and delegate the work across partners. As one state official put it, the MOUs are trying "to mature that relationship and define everyone's strength."

  Several states believe that financial incentives can strengthen these partnerships, fostering the notion of "shared responsibility" for population health outcomes. According to one state official, population health issues like childhood obesity are multifaceted problems that require multifaceted responses, so it makes sense to hold multiple parties responsible for improvement. As a practical matter, sharing responsibility financially can be difficult. After some experience, it may be possible to quantify the gains that accrue to various partners, such as payers, from improved health, and justify a portion of the investment and risk accordingly. At this stage, states are experimenting. Oregon, for example, has given flexibility to its Coordinated Care Organizations in how they allocate savings to their partnership members.



State Example
LEVERAGING PARTNERS' EXPERTISE IN MARYLAND

In Maryland, as hospitals become accountable for population health improvement, the state is facilitating partnerships between hospitals and local organizations that have community-based care management expertise. This will enable hospitals to better manage care by taking advantage of existing expertise that they may not have had in-house. Likewise, partnering with hospitals allows the community organizations to better connect with high-need patients.

Financing & Sustainability

- **State initiatives must demonstrate a business case for delivery system stakeholders to invest in community-based prevention.**

In order for a transformation strategy to be readily embraced, states must take into account the reality of business models that drive stakeholders' decision making, and demonstrate that new initiatives fit in with stakeholders' business objectives. To that end, nearly all states described return on investment (ROI) as a key issue for engaging delivery system players in community-based work. Public health organizations, as well as government and non-profit entities, are able to focus primarily on their mission of health improvement. Private sector payers and providers, on the other hand, are driven by a business imperative. A positive return on investment is a crucial criterion for any initiative. For many community-based prevention activities, it is difficult to show a positive return on investment within a short timeframe.[49] Many state officials point out that within one- to five-year budget cycles, savings from disease prevention are unlikely to accrue to providers and payers, especially for a long-term effort like childhood obesity prevention. Other factors complicating ROI include the difficulty with attributing savings from prevention to one particular partner's actions, and with capturing savings resulting from avoided costs.

One way states can make a financial case to delivery system partners is by developing strong ROI predictions. For example, Vermont created a credible ROI prediction based on existing initiatives in health care systems, showing that community health teams (CHTs) were likely to generate a positive ROI. The goal of CHTs is to integrate community supports into the primary care setting in order to better coordinate not only medical but psycho-social care. CHTs include staff from a variety of disciplines (e.g. social work, nursing, psychology, pharmacy, and nutrition science).

States can also design measurement strategies to evaluate a program's effects and savings. Minnesota's Hennepin Health Accountable Care Organization (ACO) tracked electronic data from the four community partners involved in the intervention, to demonstrate reduced health care utilization and improved health outcomes.[50] Other states hire an independent evaluator to quantify the financial impact of their programs once implemented. North Carolina hired Milliman Actuaries to conduct such an analysis.[51]

When models do not show a significant enough return on investment to interest delivery system players, states can create financial incentives through policies. For instance, by requiring similar elements of its coordinated care model, including emphasis on community partnerships, in both its Medicaid and state employee purchasing, Oregon created a strong financial incentive for providers and payers to participate in the new models of care, otherwise they risk losing existing Medicaid and potentially future state employees' business as well. Texas created a financial incentive for providers to participate in its regional health care partnership improvement projects by giving them access to federal Medicaid matching funds for locally-driven initiatives.

DEMONSTRATING RETURN ON INVESTMENT IN STATE MODELS

- One analysis of Vermont's community health teams found that overall costs per person per month decreased 11.6%.[52]
- For previously high-utilizing enrollees, an analysis found that Hennepin Health reduced their costs of care by 40% to 95%.[53]
- An analysis found that for non-disabled children and adults in Medicaid, the Community Care of North Carolina model reduced per-member-per-month costs by 15%.[54]

- **State initiatives may need to target secondary prevention for early financial wins, with the goal of moving to primary prevention as a next phase.**

  Many states have designed their transformation strategies to focus on secondary prevention activities because they can provide earlier cost savings. For example, state policies can reduce emergency department utilization and hospital admissions by encouraging providers to manage care and creating community support for patients with existing chronic diseases like diabetes or mental health conditions. States can quantify these savings for providers and health plans relatively easily, by comparing before and after per-member per-month costs.

  Notably, several states participating in SIM (State Innovation Models) said that they have had to scale back primary prevention programs in favor of secondary prevention, because SIM grants require states to show ROI in the three-year grant period. As one interviewee described, "because the SIM program emphasizes concrete return on investment, our focus has been more on diabetes and reducing avoidable ER utilizations as opposed to prevention of obesity."

  Although state officials recognize that secondary prevention captures the "low hanging fruit" rather than the full potential of upstream prevention to improve population health, they see it as a practical first step to more far-reaching goals. By focusing on secondary prevention, delivery system and public health partners can become accustomed to working together and strengthen the relationships and infrastructure (e.g. shared data, shared budgeting for projects) required for sharing accountability. With this foundation, states predict partnerships will eventually take on more ambitious primary prevention projects, although some suspect this transition may require future policy actions.

- **The prospect of sustainable funding can motivate public health entities to partner with the delivery system.**

  In a world where public health programs are often grant-funded and therefore subject to termination when grants end, some state stakeholders have made the case to public health programs that they can find greater sustainability through partnering with the delivery system. Some states highlighted the potential for new partnerships to replace funding cuts public health agencies have already experienced during the recession, while others encouraged public health agencies to partner with delivery system stakeholders as a strategy for sustainability going forward. As an example of the latter, Maryland is encouraging its new Health Enterprise Zones (communities with intense and persistent health disparities that have come together to improve the health of their communities through advanced community-clinical linkages) to develop sustainability plans that tie into the state's broader delivery system transformation.

CONCLUSION

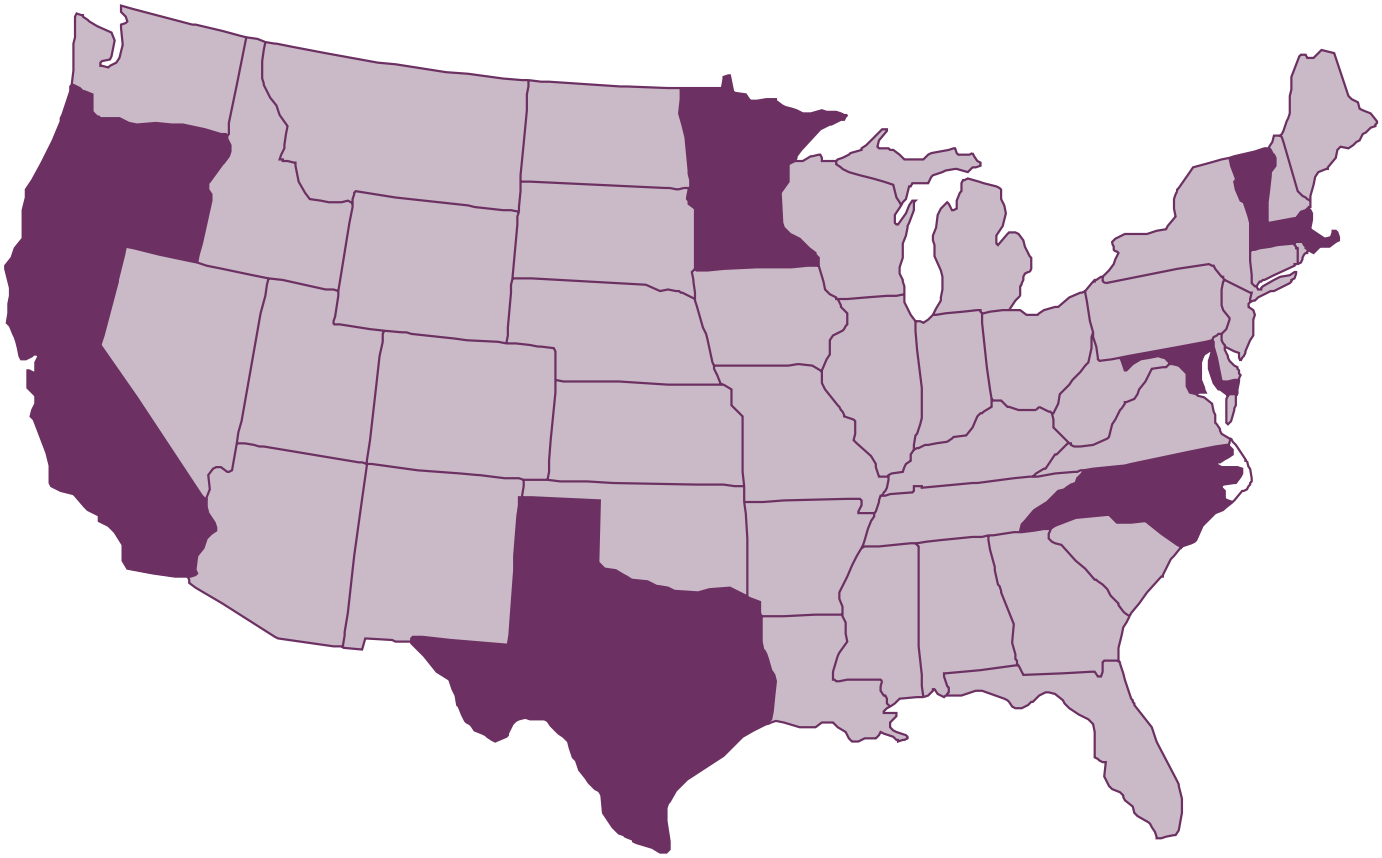
States are taking advantage of new opportunities to drive transformation in their health systems. The ACA provides a framework, new policy flexibility and federal funds to states to take on such transformational work, such as through SIM and Community Transformation Grants. For the states profiled in this report that have been driving toward greater delivery system participation in community-based initiatives prior to enactment of the ACA, those initiatives are now very much in flux as the states look to leverage the new opportunities offered. As one state official explained, there is "lots of money put out through different funding mechanisms and states are now trying to put it all together in one comprehensive initiative."

The eight states interviewed for this report are evolving their respective delivery systems to support community-based interventions by using existing federal authority and grants (e.g. Medicaid waivers and State Innovation Model [SIM] grants), delivery system reform models (e.g. accountable care, medical homes, pooled funding) and new federal requirements for non-profit hospitals (community benefit) to achieve desired results – improved care at lower costs. In addition, some of the states are determining how to replicate their efforts for other populations, including state employees, privately insured consumers and Medicare beneficiaries.

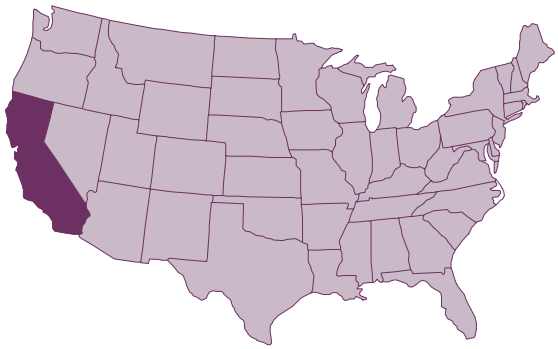
Many of these strategies — bringing stakeholders together, using Medicaid waivers, providing a community benefit through hospitals — are not new for states, delivery systems, or public health partners. Yet today's new incentives and motivations make their goals seem more attainable. States are in a unique position to weave these new and existing opportunities together in an overarching statewide strategy to transform health care and strike a new balance between the delivery and public health systems.

APPENDIX: STATE PROFILES

The following State Profiles offer an overview of how each state interviewed is steering its delivery system financing mechanisms to support community-based interventions. The profiles include an overview of current activities, implications for chronic disease prevention with specific examples related to childhood obesity when applicable, lessons learned, and next steps.



State Profile: CALIFORNIA



Overview

California is on the leading edge of a new wave of states working toward multi-stakeholder, statewide health system transformation for the first time. In May of 2012, Governor Jerry Brown established the *Let's Get Healthy California Taskforce* through executive order to work on the states' overarching strategy. This task force brought together various stakeholders including health system CEOs, non-profit organizations, commercial insurance companies, and state agencies, to develop a 10-year plan for health system transformation. Seven months later, the task force released its blueprint.[55] Let's Get Healthy California's recommendations align with public health planning that began after California received CDC funding in 2011 to develop its first statewide Wellness Plan. This plan will be implemented in 2014.[56]

In 2013, California received a $2.7 million federal State Innovation Model (SIM) Design grant to develop a State Health Care Innovation Plan (SHCIP). Referred to as CalSIM, the plan is based on the goals set forth in the Let's Get Healthy California blueprint and focuses on transforming how care is delivered and paid for in four areas: maternity care, palliative care, health homes for complex patients, and accountable care communities.[57]

In particular, CalSIM's health care homes and accountable care communities focus on the links between providers and community resources.[58] For example, the state's proposed health home model will use care teams that include community health workers. The state's Accountable Care Community model combines Minnesota's Accountable Communities for Health concept and Massachusetts's wellness trust fund concept (see Massachusetts' and Minnesota's profiles). The state would give Accountable Care Communities seed funding for a local wellness trust to be used by community partners for investments in population health improvement. After a few years, the seed funding would be replaced by savings generated by the new accountability model and reinvested into the trust. Within this framework, the state and selected communities would work out details, including how to divide accountability among partners, how much savings would go into the trust rather than back to partners, and whether to give communities a menu of options for wellness trust investments or to leave the options open.

Implications for Childhood Obesity, Chronic Disease Prevention & Management

California envisions supporting two to three pilot accountable care communities, which would build on some of the leading community-based initiatives that already exist throughout the state to prevent and manage chronic disease. For example, Live Well San Diego is now in its third year of bringing together local governments and health departments, health care providers, businesses, schools, and community organizations, to achieve 10 community-wide wellbeing goals.[59] The Humboldt County Aligning Forces for Quality project has brought community partners together around diabetes management and prevention, among other health goals.[60] In Tuolumne County, Anthem Blue Cross funded a partnership between the public school system, the local department of health, and a local health care system, to change the health curriculum in schools to reduce childhood obesity.[61] Although the state's active participation in these initiatives vary, state officials are turning to these initiatives to provide models and lessons for future models that link providers and community resources.

Lessons

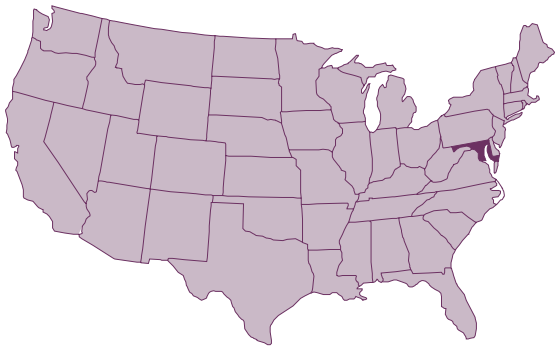
California's recent experiences suggest that the success of a model like accountable care communities, which link providers and community resources, will come down to the **strength of local partnerships and local champions.** In a state with 61 health jurisdictions (most of which are county health departments), there is wide variation in how collaborative the health care delivery system and the local public health entity have historically been. Even for a model that may have demonstrated return on investment and other benefits in some communities, the nature of these relationships at the local level will put some counties further ahead than others. For example, local health departments facing large funding cuts may not be able to support a partnership the way a privately financed provider can.

By observing the development of these local partnerships, state officials learned that **partnerships at the state level are essential** to breaking down siloes, and the state's recent efforts aimed toward this goal. Through Let's Get Healthy California and CalSIM, California has brought together agencies including Medicaid, Public Health, and the state employee benefits agency, along with the large statewide external partners, such as employers, insurers, providers, and consumer groups.[62] By facilitating these public-private partnerships at the state level, California hopes to encourage and enable more similar partnerships at the local level.

Next Steps

Under the SIM proposal, California hopes to encourage more successful partnerships by creating a financial motivation for local public health departments and providers to sit at the table together. California will conclude its SIM planning in early 2014 and apply for the larger SIM Testing grant to implement the elements of its plan. Also in 2014, the state will convene many stakeholders to begin implementing its California Wellness Plan.

State Profile: MARYLAND



Overview

Maryland has many initiatives underway that encourage delivery system investment in community-based population health activities. With the *State Innovation Model* (SIM) planning process underway, the state is determining how to unify efforts across the care continuum into an overarching strategy.

The centerpiece of the new effort will be the Community Integrated Medical Home, a concept that links clinical and community efforts for population health improvement.[63] These new medical homes would be supported by their Local Health Improvement Coalitions (LHICs) to improve health in their communities. Eighteen LHICs already exist, and include hospitals, local public health agencies, and other community partners who develop and implement improvement plans across a dashboard of population health metrics.

Through a Medicare waiver, Maryland is the only state in the country that can set standard prices for hospital services across all payers. In January 2014, Maryland received CMS approval to update its hospital payment system so that hospitals will have a global budget from all payers, which will allow them to keep savings generated from improved quality and efficiency, providing a financial incentive to partner with local public health entities and community organizations to invest in population health improvement.[64] The state has already tested a similar model in 10 hospitals that serve defined populations (such as hospitals in rural areas) under its Total Patient Revenue initiative.[65] Many of these hospitals are linking with their local LHICs, as an efficient way to improve their patient population's health. For urban areas, Maryland is developing novel ways to align public health and health care approaches to defining "populations" to foster collective accountability for population health at the community level.

Maryland's overarching transformation strategy would support these activities by building on its existing foundation for accountability through public reporting on a variety of metrics, and using its technology infrastructure to spur the flow of health information to link its currently siloed programs together.

Implications for Childhood Obesity, Chronic Disease Prevention & Management

Maryland received Community Transformation Grant (CTG) funding from the CDC to address obesity in childcare settings, schools, worksites, and communities. Maryland's CTG implementation strategy is built on principles of population health improvement, focused on promoting and facilitating the engagement of multiple LHIC partners including health departments, school systems, government agencies, and community-based organizations to provide citizens opportunities to eat healthy and increase their physical activity. Each LHIC has identified obesity as a priority and is receiving state technical assistance to implement childhood obesity initiatives. Technical assistance is also being provided to develop school health dashboards to facilitate information sharing between schools and primary care providers, and to foster between them a sense of shared responsibility to improve the health of school-aged children.

With a similar collaborative approach, Maryland will implement community integrated medical homes that are able to better address the medical as well as the non-medical determinants of health of vulnerable patients by creating stronger linkages between community-based programs, primary care providers and hospitals. One of the state's key goals is to harmonize existing and new federal opportunities to ensure the alignment of population health community strategies and further community clinical linkages between public health initiatives and the health care delivery system.

Lessons

In Maryland, a significant lesson has been the **importance of having all payers involved** in an initiative, to align around innovations to achieve common goals. With hospitals, having an all-payer payment system has helped to align financial incentives between payers to facilitate system-wide transformation and prevent cost-shifting between payers. In the 10 hospitals that are piloting a global budget payment model, the funding cap combined with increased flexibility in how the hospitals use their funding has also helped to drive hospitals toward community partnerships for population health improvement.

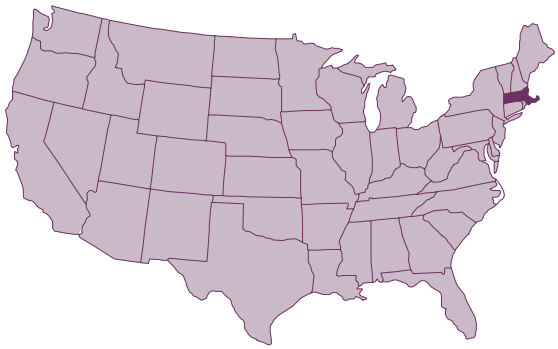
Maryland highlights its **decision to house its SIM initiative within the public health department**, rather than within Medicaid or the governor's office as other states have done. This model has successfully kept population health goals as the centerpiece of clinical transformation planning. In addition, it has helped educate delivery system stakeholders on the importance of community-based solutions as they plan their medical home and hospital payment efforts.

Next Steps

Many of the programs described have successfully fostered a sense of shared responsibility across delivery system and community entities in areas with a well-defined population. However, the immediate next step is adapting the models to work in urban and suburban areas where health systems overlap. A key strategy for making this transition has been the investment in information systems that can connect hospitals and other service providers, and identify patients and areas of need throughout the system. As the technology and payment systems evolve, Maryland hopes that those initiatives that were funded with seed grants, like LHICs and Health Enterprise Zones, will become a sustainable component of an interconnected delivery system and public health infrastructure. Maryland is completing the SIM planning process and will move toward implementing linkages across its various initiatives.

State Profile: MASSACHUSETTS

Overview



In 2012, Massachusetts enacted *Chapter 224*, a large-scale health care cost containment bill. Among the provisions of the bill, the *Massachusetts Prevention and Wellness Trust Fund* was established to focus on population health by financing evidence-based community prevention projects. The Trust Fund evolved, in part, from an established public health initiative, *Mass in Motion* (MiM). MiM was launched in 2009, and allowed Massachusetts to begin implementing community-level programs focusing on obesity and promoting healthy lifestyles. Originally funded by foundations, MiM gained additional funding through two Community Transformation Grants from the Centers for Disease Control and Prevention (CDC) to expand and enhance the program with stipulations such as the creation of community-clinical linkages.[66]

Worth $57 million, the Trust Fund was funded by a one-time assessment on insurers and hospitals with more than $1 billion in cash assets. Recognizing an unequal geographic distribution of health care costs across the state, the Trust Fund is designed to support a more focused approach linking clinical care to community resources to support comprehensive care coordination. The Trust Fund is a source of new funding from which community partnerships, (including community based organizations, local health boards, and health care providers), apply for competitive grants that are used to support formal collaborations to reduce the prevalence of chronic conditions and promote cost containment. The Trust Fund is administered by the Massachusetts Department of Public Health, with guidance from the Prevention and Wellness Advisory Board, which bring perspectives from a diverse array of public and private sector entities.

After a competitive application process, the Department awarded four-year grants from the Trust Fund to nine community partnerships in January 2014. Each grantee received up to $250,000 for its first phase of work and will receive up to an additional $1.5 million for each of the following three years. Applicants were required to demonstrate strong community-clinical linkages, a plan to improve health outcomes by reducing the prevalence of, and delivering a return on investment on at least two of four target health conditions, and a plan for reducing health disparities in their community. Finally, applicants were required to include a plan for sustainability.

Public health entities and health care providers are uniquely motivated to partner in Massachusetts. The state revised its existing 1115 waiver to allow for Medicaid to participate as a payer in delivery system transformation initiatives.[67] Medicaid and private health plans are now incentivized to move away from fee-for-service payments, with Medicaid aiming to shift 80 percent of its members into alternative payment contracts by July 2015.[68] The transition away from fee-for-service payments encourages insurers to pursue population health management initiatives, such as participating in the Trust Fund. In addition, with health care coverage greatly expanded in Massachusetts after its 2006 coverage reforms, local public health departments have shifted their focus from direct service delivery to under- and uninsured people, to improving the health of the whole population. Through the Trust Fund, public health has a new role in payment and health care reform.

Massachusetts also received a federal State Innovation Model (SIM) Testing grant in the amount of $44 million. The state is encouraging provider organizations to participate in Accountable Care Organizations (ACOs) and primary care practices to transform into patient-centered medical homes (PCMHs). Through SIM, Massachusetts is also investing in an electronic referral system that links to electronic health records, in order to facilitate community-clinical relationships between providers and community wellness resources.[69]

Implications for Childhood Obesity, Chronic Disease Prevention & Management

Chronic disease prevention and comprehensive care coordination are the guiding principles for the Trust Fund. Using research to identify four target areas with the greatest evidence for delivering return on investment, the Advisory Board selected pediatric asthma, hypertension, tobacco, and falls among older adults. Applicants for Trust Fund grants were also strongly encouraged to explore interventions for other chronic diseases, including obesity and diabetes. Although MiM has shown early success in fighting childhood obesity by lowering Body Mass Index (BMI) rates of children in several participating schools,[70] obesity was not included in the four primary areas because of the difficulty in demonstrating a short-term return on investment.

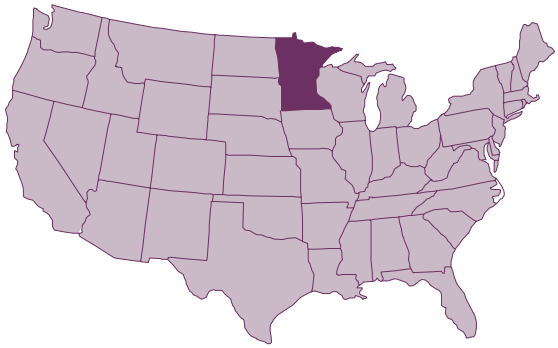
Lessons

Massachusetts has found that a crucial element for success has been **clearly defining the roles of, and benefits to, various stakeholders** involved. Since the Trust Fund is supported through an assessment on insurers and some hospitals, getting payers and providers on board was critical. By incorporating the Trust Fund into a broad cost control bill its advocates capitalized on the benefits that insurers receive in cost containment provisions. In addition to getting payers on board with the initiative, the state needed to get local public health departments excited about the new program. The Trust Fund aims to support comprehensive community policies, which is quite different than the previous approach of disparate funding streams dedicated to specific programs and diseases. State staff worked with local partners, through trainings, mentoring, and sharing lessons from early adopters to help community partnerships make this transition in thinking.

Next Steps

Massachusetts will continue to implement its SIM Testing model as Trust Fund grantees enter the six-to-ten-month capacity-building phase in early 2014. The next two years are designated for implementation and in the final year, grantees will continue implementation but also work on sustainability beyond the grant period.

State Profile: MINNESOTA



Overview

For many years, Minnesota has been moving its delivery system toward a greater focus on population health. Among the initiatives established through a 2008 comprehensive health reform law, Chapter 358 of the Laws of 2008,[71] are Health Care Homes, a multi-payer process implementing patient-centered medical home statewide, and the *Statewide Health Improvement Program* (SHIP), which provides grants to local public health departments to implement community-based prevention strategies focused on policy, system, and environmental changes.* Several initiatives the state has developed since 2008 build on this vision. Now a SIM Testing grantee, Minnesota has embarked on another planning process to determine how these initiatives, together with new investments in health information exchange, data analytics, and practice transformation, can enhance a growing Medicaid Accountable Care Organization (ACO) program and build towards an overarching state strategy, Accountable Communities for Health, which will bring providers and community partners together in a sustainable way.

Minnesota has developed two Medicaid ACO demonstrations, as well as a Community Care Team pilot in three communities that emphasize linkages between providers and community organizations. During the pilot period, each multidisciplinary team was paid, evaluated, and held responsible for patient outcomes together.[72] One ACO demonstration, the Health Care Delivery System (HCDS), began with six pilot organizations in 2013. In addition to allowing providers to share in savings if they meet total cost of care targets and quality metrics, the HCDS requires providers to demonstrate how partnerships with community-based organizations can be included in their care delivery model.

Hennepin Health, the other ACO demonstration enabled by state legislation, allows four partners (two public health care providers, the county public health department, and the county health plan) to become a formal ACO. For Medicaid beneficiaries, the state pays a set amount each month jointly to the four partners, who share in any savings or losses incurred for those patients. Under this model, primary care providers assign patients a care coordinator who connects them to behavioral health and social services such as housing. A team, including community health workers, delivers the services and shares health information electronically to coordinate services. The first year saw a decline in hospital admissions and readmissions, reduced costs for previously high-cost patients, and reached nearly 90 percent enrollee satisfaction.[73,74]

Implications for Childhood Obesity, Chronic Disease Prevention & Management

The pilot ACOs have branched into community-based initiatives to lower costs and improve outcomes. One ACO is working with county behavioral health providers to focus on services for patients with the highest behavioral health needs. Care coordinators at Hennepin Health have successfully connected clinic patients with social services, behavioral and mental health services, for which Hennepin Health pays.[75] In addition, the four partners that comprise the Hennepin Health ACO reinvest a portion of their savings into one-year projects that bolster community supports such as a Sobering Center, transitional housing and vocational services.[76] Similar investments could be made in community supports for other populations, including children, as this model is extended.

* Now in its third round of grant awards, SHIP's funding has increased to *$35 million* for the 2014-2015 biennium, and includes a special category of awards for innovative strategies.

Lessons

Minnesota has learned that **ACOs need support as they choose areas of focus and integrate functions.** For example, the ACOs need to work on using and exchanging data for quality improvement and care coordination, and on coordinating with new partners (e.g. long-term care providers and local public health agencies), all while they integrate new professionals (e.g. community health workers, community paramedics, and advanced therapists) into their care teams. The state has found that providing technical assistance and start-up grants for these activities helps ACOs broaden their focus and develop implementation strategies.

The state has also learned that **providers may need to transition to the new model in phases, and transformation may not be linear.** While some practices have experience with innovative delivery models, others do not yet have the infrastructure and expertise to support an advanced ACO in partnership with other community organizations. To address this, Minnesota has developed a continuum of accountability, with four levels of maturity representing increasing abilities to use and exchange data for care and quality improvement, partner effectively with a wide range of community partners, and provide coordinated, patient-centered care. This enables providers to focus first on coordinating within their own organizations, while preparing to branch out into community partnerships.[77]

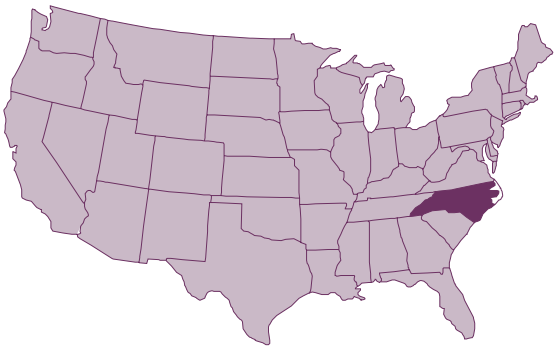
Next Steps

With its Accountable Communities for Health (ACH) initiative under SIM, Minnesota is looking to "move providers and communities towards the vision of shared accountability for the total cost of health of a population, and partnerships to improve population health."[78] ACHs will "integrate medical care, mental/chemical health, community health, public health, social services, schools and long-term supports and services," using an approach that includes local-level priority setting, flexibility on identifying target populations, and community advisory bodies that fully reflect both populations served and the range of providers involved in ensuring health for that population.[79] In the ACH model, accountability begins at the provider level, as opposed to the plan level used in other models (such as Oregon's).

Minnesota will establish three pilot ACH communities in 2014, and roll out up to 12 additional ACHs by the following year.[80] The state anticipates that hospital community needs assessments will guide local decisions on how to select the ACH's improvement activities, population, and partners, as part of an overall approach that focuses on allowing communities to decide the approach that will best help them achieve the overall vision of Minnesota's SIM grant.

State Profile: NORTH CAROLINA

Overview



The infrastructure of *Community Care of North Carolina* (CCNC), established in 1998, enables the state to support community-based public health initiatives through delivery system financing. CCNC is a statewide organization with 14 regional community care networks, including physicians, nurses, pharmacists, hospitals, health departments, social service agencies, and community partners.

The networks individually operate as non-profit organizations and aim to better serve the needs of the Medicaid and other vulnerable populations through a Patient-Centered Medical Home model. Each network is staffed with a program director, medical director, consultant pharmacists, various medical and behavioral care managers, pediatric and adult quality improvement specialists, psychiatrists, and care coordinators. Networks provide primary care providers with quality improvement support, access to data through an informatics center, patient management tools, and population management support such as care management, behavioral health integration, and pharmacy support.

This regional foundation allows networks to initiate community-based population health projects, addressing the unique needs of the local areas served. The CCNC medical home structure incentivizes physicians to address population health needs and provide chronic disease management and care coordination by funding practices to conduct a host of activities, including connecting patients to needed community resources. Medicaid, through a State Plan Amendment, reimburses participating physicians on a fee-for-service basis with an additional per-member per-month (PMPM) payment for providing care management and preventive services. Medicaid finances the management activities of the 14 local networks also through PMPM payments.[81]

Implications for Childhood Obesity, Chronic Disease Prevention & Management

CCNC considers chronic disease prevention and management a top priority; networks are currently participating in several program-wide initiatives. CCNC networks have the option to participate in state-level initiatives of this type; they receive state support in the form of data, quality improvement support, payment, and population management techniques for doing so.

CCNC first ran a childhood obesity grant-funded pilot from 2008-2011. Five participating CCNC networks addressed childhood obesity by asking health care providers to connect families with resources in the community that encourage better nutrition and increased physical activity. This grant laid the groundwork for local networks to link to large-scale initiatives such as Eat Smart, Move More North Carolina, a statewide obesity initiative promoting healthy lifestyle choices in communities, schools, and businesses. CCNC providers continued to implement obesity initiatives after the completion of the grant by working with community partners, such as the YMCA, to link low-income families with local farmers' markets.

More recently, the state's Secretary of the Department of Health and Human Services made childhood obesity prevention a top priority. The Department received a quality demonstration grant, funded by the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009. This demonstration identified childhood obesity as one of its quality improvement initiatives. Through this project, quality improvement specialists work with CCNC primary care practices to properly record body mass index percentiles and provide training in population management and assistance in linking patients to additional community resources. The CHIPRA grant has also supported training in motivational interviewing techniques for CCNC primary care clinicians.[82] Dieticians from multiple networks worked with the CHIPRA grant team to create visual, low-literacy family materials based on motivational interviewing approaches for use in the medical home.

Lessons

One CCNC success factor has been **collaborations that support community-based interventions.** Networks contract with local health departments for services. Pediatric nurses and social workers who provide care coordination services are hired by local health departments but financed through CCNC contracts. They work with families by promoting preventive services, developmental screening, and connections to community resources, to address issues including toxic stress and psychosocial difficulties that can impact overall health. Obstetric care managers are linked with obstetricians in networks to identify pregnant, high-risk, Medicaid beneficiaries to make sure they have a pregnancy medical home. These programs are connected so that when an obstetrician care manger identifies a high-risk pregnant woman, they connect with children's care coordinators to ensure that they provide follow-up care once the child is born. These are integrated programs between CCNC networks and local health departments. Although public health activities may not be directly financed through CCNC, CCNC is financing the connection through network staff.

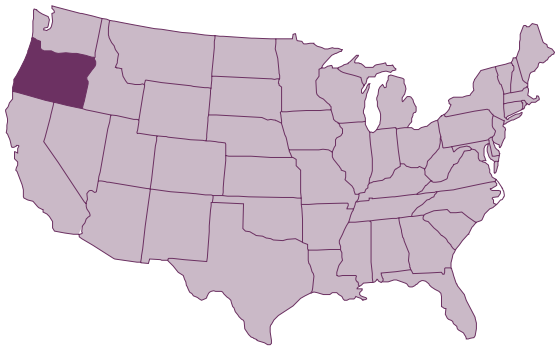
CCNC has used its regional structure to **pilot projects in several networks before expanding initiatives statewide.** Project-related grants can help jumpstart initiatives that become integrated into the CCNC infrastructure, such as the pediatric quality improvement specialists.

As networks make decisions about which initiatives to fund, they are drawn to initiatives that prove their value. For example, initiatives that lead to reductions in emergency department utilization have proven their value and continue to be funded.

Next Steps

North Carolina's primary focus going forward will be to ensure the sustainability of effective projects. For example, due to their large impact, CCNC networks plan to sustain the quality improvement specialists after the grant period comes to an end.

State Profile: OREGON



Overview

Oregon's Coordinated Care model began with *Coordinated Care Organizations* (CCO), the state's version of accountable care, created in 2012 under a Medicaid 1115 waiver. Now a SIM Testing grantee, the state plans to expand its Coordinated Care model to other populations including state and school employees. A CCO is a community-level entity that finances health care and is formally structured as a partnership of payers, providers, and community organizations that assumes global risk for an area's Medicaid patients. CCOs can be thought of as a blend of managed care and accountable care that encompasses a whole community. CCOs are required to establish Community Advisory Councils bringing together stakeholders, assess community needs and develop transformation plans to meet those needs. Currently, there are 16 CCOs in Oregon.

The CCOs are paid a flat amount, a "global budget" with a fixed trend rate, from the state for their Medicaid patients and they receive additional incentive payments for meeting performance metrics such as conducting depression screening and enrolling patients in medical homes.[83] By assuming global risk, and through incentive payments, CCOs stand to benefit financially from improving health and health care. To generate savings and improve performance, CCOs have flexibility to pay providers in innovative ways, and to implement other transformation strategies within their communities. Key to CCOs is that they incorporate much more than physical health care — wrapping dental, mental health, and certain social supports into a single financing mechanism — thus "coordinating" care in all aspects.

Through additional investment from Oregon's Legislature in 2013, a Transformation Fund is available to CCOs for innovative projects that help them meet improvement goals. Among other requirements, CCOs are encouraged to use community health workers or peer wellness counselors and are required to conduct community needs assessments.[84] The state is monitoring CCO outcomes across a number of metrics and data sources, including population-level health, to gauge the success of the coordinated care model as it gets adopted.

Implications for Childhood Obesity, Chronic Disease Prevention & Management

Because Oregon's CCOs are accountable for improving population health, they have an incentive to directly invest the funds they receive from Medicaid and/or encourage providers to invest in community-based population health improvement. For example, CCOs can take such steps as funding community health workers and outreach campaigns. Many CCOs have identified obesity as a key area of focus.

CCOs will strengthen connections to community-based interventions with the launch of Early Learning Hubs, which are CCO-like entities for education and early childhood development. The CCOs will be required to coordinate with their community Early Learning Hubs, presenting new opportunities for community-based initiatives, particularly around pediatric wellness and population health. In some cases, the same entity that is currently serving as a CCO has also applied to be an Early Learning Hub, further enhancing opportunities for coordination toward health improvement goals.

Lessons

Stakeholder involvement has been crucial to Oregon's efforts. At the initial stage, Oregon had broad stakeholder support for the concept of CCOs. Providers recognized they could not do everything in a clinical setting and needed other supports and systems in place to be successful. **Because some of the stakeholders involved had never worked together before, the state soon realized that the community partners needed help organizing.** Many technical questions arose, and it was sometimes difficult for the state to coordinate responses coming from multiple state agencies. The state created "innovator agents" who are hired by the state and assigned to a CCO. Innovator agents serve as a conduit for the CCO to ask questions and garner responses from state agencies.

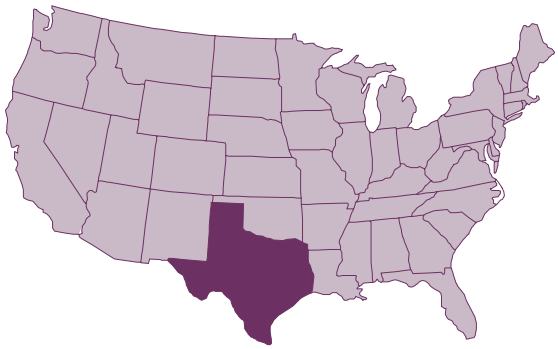
Continuing stakeholder involvement has been very important as CCOs roll out. Oregon has managed to **keep stakeholders engaged by demonstrating benefits of engagement.** For example, public health entities, hospitals, and CCOs all face separate requirements to conduct community risk assessments and create plans for improvement. The state is looking to align requirements so that the stakeholders can satisfy their respective community risk assessment/planning processes at the same time with the CCO. Providing technical assistance, such as facilitating connections to experts and programs already engaged in best practices (e.g. around smoking cessation) is another way stakeholders benefit from CCO participation.

Oregon has also set up a new Health System Transformation Center to facilitate learning collaboratives with the CCO medical directors, quality improvement teams, and others across CCOs so they can learn from each other and share best practices. **The learning collaborative platform has been a helpful way to bring both the state and regional public health entities into a conversation** with all of the CCOs.

Next Steps

Oregon is considering how to accomplish the Triple Aim for the commercially insured population in addition to publicly-insured groups. Oregon plans to spread its Coordinated Care model to other insured groups in the next few years through its SIM initiative. The state is also considering certain policy levers, such as contracting or rate regulation requirements that mandate that commercial payers invest in community strategies, to incent commercial payers to invest in community-based population health, either through a CCO-like model or other means. Another possible tactic is including community investment in quality scores or featuring plans on the state's insurance exchange, especially those that implement community-based population health strategies.

State Profile: TEXAS



Overview

Texas is using a Delivery System Reform Incentive Payment (DSRIP) pool, established under a *Medicaid 1115 waiver* approved by the federal government in December 2011 and authorized through Septempber 30, 2016, to establish a structured regional organization that facilitates community collaboration. Along with expanding Medicaid managed care statewide, the waiver authorizes Texas to redistribute its Upper Payment Limit (UPL) funds that previously went to hospitals to compensate for low Medicaid payment rates, into two new funding pools – an uncompensated care pool and the DSRIP pool. Together, they total $29 billion. Rather than using state general funds, the state share of funding for these two pools comes largely from intergovernmental transfers from health care taxing entities such as hospital districts, health science universities, counties, cities and health departments. This locally-raised funding is matched with federal dollars up to the annual limit of each of the pools.

The DSRIP funding is available to Regional Health Partnerships (RHPs) to support delivery system innovations that "enhance access to health care, increase the quality of care, the cost-effectiveness of care provided and the health of the patients and families served."[85] By repurposing some of the UPL funding that hospitals previously received in compensation, DSRIP provides both an incentive (potential for providers to earn about $4.3 billion in DSRIP funds[86] over the first two years of the projects[87]), and flexibility (the funding for innovations beyond direct services) for hospitals and communities to invest in improvement projects and prevention.

The Texas Health and Human Services Commission (HHSC) established 20 RHPs in May 2012, each having a geographic boundary and coordinated by a public hospital or local governmental entity. RHPs include public and private hospitals, physician groups, community mental health centers, local health departments, and others.[88] RHPs are required to promote "system transformation" by developing a delivery system reform and improvement plan that includes a selection of projects eligible for DSRIP funding, generated by HHSC, and approved by CMS. There are four categories of projects that an RHP can select from. Of these, two are specific projects geared towards evidence-based health promotion and disease prevention. Of the 1,300 projects submitted by RHPs for CMS approval, 100 projects that fall into the evidence-based health promotion and disease prevention programs have been approved and are in progress.

Implications for Childhood Obesity, Chronic Disease Prevention & Management

Through the DSRIP pool, Texas is shifting more resources away from direct service delivery to earlier stages in care delivery, not only to improve the efficiency of the state's delivery system but also to promote better health for its communities. The structure of RHPs positions the state to address chronic disease prevention and management at a local level with community-based solutions. Obesity and diabetes are two areas of particular concern for Texas and "implement[ing] innovative evidence-based strategies to reduce and prevent obesity in children and adolescents" is an explicitly suggested aim for RHPs.[89] As of October 2013, RHPs have developed at least six projects specifically pertaining to childhood obesity. Two programs utilize the community-based Coordinated Approach to Child Health (CATCH) program, which promotes exercise, healthy eating, and tobacco prevention.[90]

Lessons

Since the waiver took effect in 2011, providers have shown strong interest, resulting in 20 RHPs and over 1200 projects approved thus far, so the state sees much promise in RHPs. At the same time, **implementing a high volume and large variety of locally driven DSRIP projects across a large state in the past two years has proven to be challenging**. For the program to be successful, Texas has had to prioritize establishing RHPs and getting the projects off the ground, resulting in little time to coordinate and integrate the large variety of initiatives.

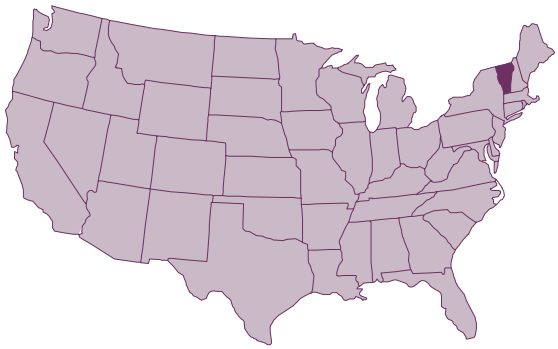
Achieving this large-scale reform on a tight timeline has required cooperation from multiple entities. Texas quickly learned the importance of opening lines of communication and fostering new relationships across agencies. For example, local health departments now play a crucial role in the creation and implementation of DSRIP projects. Part of the success in the involvement of local health departments can be attributed to the technical assistance they received from the Department of State Health Services, the state's public health agency, in **translating the Medicaid waiver's complex language into public health language** more readily understood by locally based entities. Texas has further encouraged transparency by requiring RHPs to hold a public meeting before they propose a project and by having the largest regions convene regional learning collaboratives.

Similar to other states addressing population health issues, Texas finds it **challenging to demonstrate the benefits of population-health initiatives in a short timeframe.** The state intended to show an improvement in public health outcomes by years four and five of the waiver; however, public health interventions often take five years or more for outcomes to be realized. Texas is currently working with CMS to adjust the benchmarks and standards for public health outcomes.

Next Steps

State employees are focusing most of their attention on getting the approved RHP projects running. Going forward, the state will support additional RHP projects and begin evaluation. Broad goals for the waiver period include streamlining diverse waiver implementation efforts, improving the reporting process for RHP projects to quantify their impact, utilizing quality improvement and learning collaboratives to gain a better understanding of effective strategies, and developing additional partnership between various entities to achieve common goals. Looking beyond its 1115 waiver, Texas is exploring options for sustaining the projects implemented under the waiver.

State Profile: VERMONT



Overview

Vermont has a long history of addressing population health through delivery system initiatives. *Vermont's Blueprint for Health* (Blueprint) addresses chronic disease prevention and management at the primary care level. Vermont launched the Blueprint in 2003 as an initiative from the Governor's office, in an effort to transform the health care delivery system and achieve better health outcomes across the state. This is accomplished through various efforts such as transforming primary care practices into Patient-Centered Medical Homes (PCMHs), utilizing Community Health Teams (CHTs) and the Support and Services and Home (SASH) program, funded through the Centers for Medicare and Medicaid Innovation Center Multi-payer Advanced Primary Care Practice (MAPCP) demonstration.

CHTs are a major tenet of Vermont's Blueprint. The goal of CHTs is to integrate community supports into the primary care setting in order to better coordinate not only medical but psycho-social care. CHTs are developed and hired at the community level in order to address the specific needs of a community and include staff from a variety of disciplines (e.g. social work, nursing, psychology, pharmacy, and nutrition science). The SASH program is essentially an extension of CHT services with a focus on providing non-medical in-home services to Medicare beneficiaries. The SASH program is administered through the regional housing authorities to enhance care for particularly high-need patients.[91]

Providers recognized as a PCMH receive an additional per patient per month payment that, among other things, incentivizes increased care coordination and preventive health measures. To support CHTs, communities are allocated an amount of money proportional to the population served by the area's primary care practices. The community is responsible for deciding how to spend this money and how to develop their CHTs.

With the Blueprint underway for several years, Vermont has already reported some initial promising results, such as a decrease in the growth of health care expenditures per person and a reduction in hospitalization rates.[92]

Vermont also has a Medicaid 1115 waiver that supports many public health initiatives through the state's Global Commitment program. For instance, a funded community fluoridation initiative improves the health of the Medicaid population by improving dental health at a population level. The Global Commitment waiver can also fund self-management programs that are not funded by insurers under the Blueprint.

Implications for Childhood Obesity, Chronic Disease Prevention & Management

The CHT in Burlington is an example of how a CHT can address childhood obesity. CHT members first work with pediatric care professionals to identify obese or overweight children and then meet with the patients and their families to direct them toward helpful community resources (such as walking paths or athletic leagues). CHT staff members have also established a relationship with fitness facilities in this region. Furthermore, the CHT is able to identify other barriers to health, such as poor access to healthy foods, and assist families in overcoming them. In addition to the services provided to individuals, a CHT also identifies issues faced by a community and works with community partners to find solutions. For instance, a CHT recognizing a community's lack of recreation services or unhealthy school lunches can follow up with the appropriate community member who can address the issue.

Lessons

Vermont developed a strong return on investment model that has enabled the state to garner support and participation in the Blueprint from stakeholders including insurers, providers, and public health agencies. The state emphasized that the foundation for the Blueprint was chronic disease *prevention*, and that costs savings would result from preventing diseases from occurring.

The localized structure of Blueprint initiatives has revealed additional important lessons for the state. First, **by piloting the Community Health Team model in several communities, Vermont was able to show insurers the feasibility of implementing Blueprint projects on a small scale before expanding.** Community-level innovation presents a unique opportunity for both delivery system and public health officials to collaborate at the local level and divide up the work where most appropriate for each community, at times redefining traditional responsibilities.

In addition to local collaboration, the Vermont Department of Health and Blueprint have divided up roles across the delivery system and public health entities. For example, as part of Blueprint implementation discussions, the Department of Health and Blueprint have collaborated on quality improvement in primary care practices, with the Department of Health using its data to identify gaps in services such as cancer screening, and the Blueprint using practice facilitators to coach medical practices in making process improvements to implement these high priority guidelines for care.

Next Steps

With support from a SIM Testing grant, Vermont plans to expand its care model and also enter a new phase of payment reform. Most relevant for this project, Vermont's SIM grant will expand a Medicare shared savings ACO model to include Medicaid and commercial payers,[93] and introduce pay for performance payments.

A "Hub & Spoke" system will establish community-clinical linkages between regional addiction centers and primary care providers in an effort to truly coordinate care. Vermont Medicaid, Department of Health, and the Blueprint have partnered in the development of this model. The Hub & Spoke model will be largely funded through Medicaid with a payment model similar to the one being used to support CHTs.[94]

ENDNOTES

[1] Hester J. *Integrating Population Health into Delivery System Reform.* Presented at Institute of Medicine Population Health Roundtable. June 2013. Available at: *www.iom.edu/~/media/Files/Activity%20Files/PublicHealth/PopulationHealthImprovementRT/13-JUN-13/Presentations/9_Jim_Hester.pdf* ; Robert Wood Johnson Foundation Public Health Blog. *Public Health and Health Care Working Together: Paul Kuehnert Q&A.* Nov. 2012. Available at: *www.rwjf.org/en/blogs/new-public-health/2012/11/public_health_andhe.html*

[2] McGinnis J. "Can Public Health and Medicine Partner in the Public Interest?" *Health Affairs*, 25(4): 1044-1052, 2006. Available at: *http://content.healthaffairs.org/content/25/4/1044.full?sid=f18da221-dd56-4adf-b401-4f7dcc649060;* Hester JA. Paying for Population Health: *A View of the Opportunity and Challenges in Health care Reform.* Washington, DC: Institute of Medicine, 2013. Available at: *http://iom.edu/Global/Perspectives/2013/PayingForPopulationHealth.aspx*

[3] ACA §9007; Internal Revenue Service (Apr. 5 2013). *Proposed Rule: Community Health Needs Assessments for Charitable Hospitals.* Federal Register 78 FR 20523.

[4] Kindig D, and Stoddart G. "What is Population Health?" *American Journal of Public Health*, 93(3): 380-383, 2003. Available at: *http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.93.3.380*

[5] Berwick D, Nolan T, and Whittington J. "The Triple Aim: Care, Health, And Cost." *Health Affairs,* 27(3): 759-769, 2008. Available at: *http://content.healthaffairs.org/content/27/3/759.full*

[6] Hester JA. *Paying for Population Health: A View of the Opportunity and Challenges in Health care Reform.* Washington, DC: Institute of Medicine, 2013. Available at: *http://iom.edu/Global/Perspectives/2013/PayingForPopulationHealth.aspx*

[7] Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century.* Washington, DC: The National Academies, 2001. Available at: *www.nap.edu/openbook.php?record_id=10027&page=25*

[8] McGinnis JM, Williams-Russo P, and Knickman J. "The Case for More Active Policy Attention to Health Promotion." *Health Affairs,* 21(2): 80, 2002. Available at: *http://content.healthaffairs.org/content/21/2/78.full.pdf+html*

[9] Martin A, Hartman M, Whittle L, et al. "National Health Spending in 2012: Rate of Health Spending Growth Remained Low for the Fourth Consecutive Year." *Health Affairs,* 33 (1): 67-77, 2014. Available at: *http://content.healthaffairs.org/content/33/1/67.full#T2*

[10] The Organisation for Economic Co-operation and Development. *OECD Health Data 2013: How Does the United State Compare.* 2013. Available at: *www.oecd.org/unitedstates/Briefing-Note-USA-2013.pdf*

[11] The Organisation for Economic Co-operation and Development. *Health at a Glance 2013: OECD Indicators.* OECD Publishing. Available at: *www.oecd.org/els/health-systems/Health-at-a-Glance-2013.pdf*

[12] McGinnis J, and Foege W. "Actual Causes of Death in the United States." JAMA, 270(18): 2207-2212, 1993. Available at: *http://jama.jamanetwork.com/article.aspx?articleid=409171; http://jama.ama-assn.org/content/291/10/1238.short*

[13] Martin A, Hartman M, Whittle L, et al. "National Health Spending in 2012: Rate of Health Spending Growth Remained Low for the Fourth Consecutive Year." *Health Affairs*, 33 (1): 67-77, 2014. Available at: *http://content.healthaffairs.org/content/33/1/67.full#T2*

[14] Centers for Disease Control and Prevention. *Chronic Disease Prevention and Health Promotion.* 2012. Available at: *www.cdc.gov/chronicdisease/overview/index.htm#1*

[15] Institute of Medicine. *For the Public's Health: Investing in a Healthier Future.* Washington, DC: The National Academies, 2012. Available at: *http://books.nap.edu/openbook.php?record_id=13268&page=1*

[16] The New York Academy of Medicine. *A Compendium of Proven Community-Based Programs.* New York, NY: New York Academy of Medicine, 2009. Available at: *http://healthyamericans.org/assets/files/NYAM_Compendium.pdf*

[17] Institute of Medicine. *An Integrated Framework for Assessing the Value of Community-Based Prevention.* Washington, DC: The National Academies, 2012. p.31. Available at: *http://books.nap.edu/openbook.php?record_id=13487&page=31*

[18] Trust for America's Health. *Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities.* 2008. Available at: *http://healthyamericans.org/reports/prevention08/Prevention08Exec.pdf*

[19] Milstein B, Homer J, Briss P, et al. "Why Behavioral and Environmental Interventions are Needed to Improve Health at Lower Cost." *Health Affairs,* 30(5): 832-832, 2011. Available at: *http://content.healthaffairs.org/content/30/5/823.full.pdf+html*

[20] Harvard School of Public Health. *Obesity Consequences: Economic Costs.* Available at: *www.hsph.harvard.edu/obesity-prevention-source/obesity-consequences/economic/*

[21] Centers for Disease Control and Prevention. *Obesity and Extreme Obesity Rates Decline Among Low-income Preschool Children.* 2014. Available at: *www.cdc.gov/obesity/data/childhood.html*

[22] The Organisation for Economic Co-operation and Development. *Obesity and the Economics of Prevention: Fit not Fat – United States Key Facts.* 2010. Available at: *www.oecd.org/els/health-systems/obesityandtheeconomicsofpreventionfitnotfat-unitedstateskeyfacts.htm*

[23] The Organisation for Economic Co-operation and Development. *Obesity Update* 2012. 2012. Available at: *www.oecd.org/health/49716427.pdf*

[24] Whitaker R, Wright J, Pepe M, et al. "Predicting Obesity in Young Adulthood from Childhood and Parental Obesity." *New England Journal of Medicine,* 337: 869-873, 1997. Available at: *www.nejm.org/doi/full/10.1056/NEJM199709253371301*

[25] Guo S, Chumela W, and Roche A. "Predicting Overweight and Obesity in Adulthood From Body Mass Index Values in Childhood and Adolescence." *American Journal of Clinical Nutrition,* 76(3): 653-658, 2002. Available at: *http://ajcn.nutrition.org/content/76/3/653.long*

[26] Centers for Disease Control and Prevention. *Childhood Obesity Facts*. 2013. Available at: *www.cdc.gov/healthyyouth/obesity/facts.htm*

[27] Centers for Disease Control and Prevention. *Coordinated Chronic Disease Program: State Activities.* 2012. Available at: *www.cdc.gov/coordinatedchronic/state_activities.html*

[28] Centers for Medicare & Medicaid Services. *State Innovations Models Initiative: Frequently Asked Questions.* Available at: *http://innovation.cms.gov/initiatives/State-Innovations/State-Innovation-Models-Initiative-Frequently-Asked-Questions.html#collapse-question5*

[29] Berwick D, Nolan T, and Whittington J. "The Triple Aim: Care, Health, And Cost." *Health Affairs,* 27(3): 759-769, 2008. Available at: *http://content.healthaffairs.org/content/27/3/759.full;* Agency for Healthcare Research and Quality. *The National Quality Strategy.* Available at: *www.ahrq.gov/workingforquality/*; Surgeon General. *National Prevention Strategy.* Available at: *www.surgeongeneral.gov/initiatives/prevention/strategy/*

[30] For more information on these initiatives see, Delivery system transformation provisions: *www.nashp.org/sites/default/files/state.strategies.improve.quality.efficiency.pdf;* Chronic disease prevention provisions: *www.apha.org/NR/rdonlyres/763D7507-2CC3-4828-AF84-1010EA1304A4/0/FinalPreventionACAWeb.pdf.* Please note that not all programs referenced in Table 1 have received funding and been implemented.

[31] Centers for Medicare & Medicaid Services, Waivers, Available at: *www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html*

[32] For additional information on Medicaid waivers, please see *www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html*

[33] The Kaiser Commission on Medicaid and the Uninsured. *Medicaid Financing: An Overview of the Federal Medicaid Matching Rate.* Washington, DC: Kaiser Family Foundation, 2012. Available at: *http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8352.pdf*

[34] Centers for Medicare & Medicaid Services, Section 1115 Demonstrations, *www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Section-1115-Demonstrations.html* (last visited Feb. 5, 2014).

[35] National Academy for State Health Policy, Medical Home & Patient-Centered Care, Available at: *http://nashp.org/med-home-map*

[36] Fisher E. "Building a Medical Neighborhood for the Medical Home." *The New England Journal of Medicine.* 359: 1202-1205, 2008. Available at: *www.nejm.org/doi/full/10.1056/NEJMp0806233*

[37] Takach M and Buxbaum J. *Care Management for Medicaid Enrollees Through Community Health Teams.* New York, NY: The Commonwealth Fund, 2013. Available at: *http://nashp.org/sites/default/files/1690_Takach_care_mgmt_Medicaid_enrollees_community_hlt_teams_520.pdf*

[38] *Ibid.*

[39] National Academy for State Health Policy, Medical Home & Patient-Centered Care, Available at: *http://nashp.org/med-home-map*

[40] *Ibid.*

[41] Purington K, Gauthier A, Patel S, et al. *On the Road to Better Value: State Roles in Promoting Accountable Care Organizations.* New York, NY: The Commonwealth Fund, 2011. Available at: *www.nashp.org/sites/default/files/state.roles_.for_.promoting.aco_.pdf*

[42] Gourevitch M, Cannell T, Boufford J, et al. "The Challenge of Attribution: Responsibility for Population Health in the Context of Accountable Care." *American Journal of Public Health,* 102(3): S322-S324, 2012. Available at: *www.ncbi.nlm.nih.gov/pubmed/22690966*

[43] Centers for Medicare & Medicaid Services. *About the CMS Innovation Center.* Available at: *http://innovation.cms.gov/About/index.html*

[44] Centers for Medicare & Medicaid Services. *Fact Sheets: Details for State Innovations Models Initiative.* Available at: *www.cms.gov/apps/media/press/factsheet.asp?Counter=4546&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date*

[45] Centers for Medicare & Medicaid Services. *State Innovations Models Initiative: General Information.* Available at: *http://innovation.cms.gov/initiatives/state-innovations/*

[46] ACA §9007; Internal Revenue Service (Apr. 5 2013). Proposed Rule: "Community Health Needs Assessments for Charitable Hospitals" Federal Register 78 FR 20523.

[47] Kaiser Family Foundation. *Hospitals by Ownership Type.* Available at: *http://kff.org/other/state-indicator/hospitals-by-ownership/*

[48] Transformation Center. 2014 *Statewide Schedule for CCO Learning Collaborative.* Available at: *http://transformationcenter.org/wp-content/uploads/2013/12/2014-Schedule-Statewide-CCO-Learning-Collaborativex.pdf*

[49] Woolf S, Husten C, Lewin L, et al. *The Economic Argument for Disease Prevention: Distinguishing Between Value and Savings.* 2009. Available at: *www.prevent.org/data/files/initiatives/economicargumentfordiseaseprevention.pdf*

[50] Agency for Healthcare Research and Quality. *County-Based Accountable Care Organization for Medicaid Enrollees Features Shared Risk, Electronic Data Sharing, and Various Improvement Initiatives, Leading to Lower Utilization and Costs. P*artnership for Prevention. 2013. Available at: *www.innovations.ahrq.gov/content.aspx?id=3835*

[51] Cosway R, Girod C, and Abbott B. *Analysis of Community Care of North Carolina Savings.* San Diego, CA: Milliman Inc., 2011. Available at: *www.communitycarenc.org/media/related-downloads/milliman-cost-savings-study.pdf*

[52] Bielaszka-DuVernay C. "Vermont's Blueprint for Medical Homes, Community Health Teams, and Better Health at Lower Cost." *Health Affairs*, 30(3): 383-386, 2011. Available at: *http://content.healthaffairs.org/content/30/3/383.full#ref-5*

[53] Agency for Healthcare Research and Quality. *County-Based Accountable Care Organization for Medicaid Enrollees Features Shared Risk, Electronic Data Sharing, and Various Improvement Initiatives, Leading to Lower Utilization and Costs.* 2013. Available at: *www.innovations.ahrq.gov/content.aspx?id=3835*

[54] Cosway R, Girod C, and Abbott B. *Analysis of Community Care of North Carolina Savings.* San Diego, CA: Milliman Inc., 2011. Available at: *www.communitycarenc.org/media/related-downloads/milliman-cost-savings-study.pdf*

[55] California Health and Human Services Agency. *Press Release: California Awarded $2.7M Federal Grant to Design Health Care Payment Reform Model.* February 2013. Available at: *www.chhs.ca.gov/PRI/CMMIRelease.pdf*

[56] California Department of Public Health. *California Wellness Plan.* 2013. Available at: *www.cdph.ca.gov/programs/cdcb/Pages/CAWellnessPlan.aspx*

[57] California Health and Human Services Agency. *DRAFT State Health Care Innovation Plan.* 2013, p.9. Available at: *www.chhs.ca.gov/PRI/CalSIM%20SHCIP%20Working%20Draft%2010-10.pdf*

[58] California Health and Human Services Agency. *DRAFT State Health Care Innovation Plan.* 2013, p.8. Available at: *www.chhs.ca.gov/PRI/CalSIM%20SHCIP%20Working%20Draft%2010-10.pdf*

[59] For more information see: *http://livewell.agencystagingserver.com/about/*; Live Well San Diego. *Third Year Annual Report.* 2013. Available at: *www.sdcounty.ca.gov/dmpr/gfx/Live_Well_Annual_Report_2012-13/*

[60] For more information see: *www.aligningforceshumboldt.org*

[61] For more information see: *www.tcbeatsobesity.com/index.html*

[62] California Health and Human Services Agency. *Let's Get Healthy California/CMMI State Innovation Model: The Triple Aim.* Available at: *www.chhs.ca.gov/Documents/Let%27s%20Get%20Healthy%20California%20State%20Innovation%20Model%20(CalSIM)%20Work%20Group%20Composition.pdf*

[63] Maryland Department of Health and Mental Hygiene. *Maryland's SIM State Health Innovation Plan.* 2013. Available at: *http://hsia.dhmh.maryland.gov/Documents/CIMH%20Project%20Narrative.pdf*

[64] Maryland Department of Health and Mental Hygiene. *Maryland Submits Proposal to Modernize All-Payer System.* 2014. Available at: *http://dhmh.maryland.gov/SitePages/Medicare%20Waiver%20Modernization.aspx*

[65] The Maryland Health Services Cost Review Commission. *Total Patient Revenue Rate Setting Methodology.* Available at: *www.hscrc.state.md.us/init_tpr.cfm*

[66] The Northeastern University Institute on Urban Health Research and Practice. *The Massachusetts Prevention and Wellness Trust: An Innovative Approach to Prevention as a Component of Health Care Reform.* Boston, MA: Institute on Urban Health Research and Practice, 2013. Available at: *www.northeastern.edu/iuhrp/wp-content/uploads/2013/12/PreventionTrustFinalReport.pdf*

[67] Massachusetts Executive Office of Health and Human Services Office of Medicaid. *Section 1115 Demonstration Project Extension Request.* 2013. Available at: *www.mass.gov/eohhs/docs/eohhs/cms-waiver/ma-1115-demonstration-extension-09-30-13.pdf*

[68] Gosline A, and Rodman E. *Summary of Chapter 224 of the Acts of 2012.* Boston, MA: Blue Cross Blue Shield of Massachusetts Foundation, 2012. Available at: *http://bluecrossmafoundation.org/sites/default/files/download/publication/Chapter%20224%20summary_2.pdf*

[69] State Refor(u)m. *A Closer Look at State Innovation Model Testing Winning States: Payment and Delivery System Reform Analysis.* Available at: *www.statereforum.org/state-innovation-model-chart*

[70] Mass in Motion. *Mass in Motion Communities Show Significant Decreases in Childhood Obesity Rates: Early Analysis Shows Promising Trend.* 2012. Available at: *www.mass.gov/eohhs/docs/dph/mass-in-motion/bmi-success-story.pdf*

[71] Minnesota Department of Health. *Minnesota's 2008 Health Reform Law. www.health.state.mn.us/healthreform/about/*

[72] Minnesota Health Policy, Health Care Homes. *Minnesota Community Care Team Pilot.* June 2013. Available at: *www.health.state.mn.us/divs/hpcd/chp/cvh/documents/CTGFactSheet.pdf*

[73] Agency for Healthcare Research and Quality. *County-Based Accountable Care Organization for Medicaid Enrollees Features Shared Risk, Electronic Data Sharing, and Various Improvement Initiatives, Leading to Lower Utilization and Costs.* 2013. Available at: *www.innovations.ahrq.gov/content.aspx?id=3835*

[74] Hennepin County. *Hennepin Health Proposal: A Social Disparities Approach to Health & Health Care.* 2011. Available at: *www.hennepin.us/~/media/hennepinus/residents/health-medical/documents/hennepin-health-proposal-110711.pdf*

[75] Agency for Healthcare Research and Quality. *County-Based Accountable Care Organization for Medicaid Enrollees Features Shared Risk, Electronic Data Sharing, and Various Improvement Initiatives, Leading to Lower Utilization and Costs.* 2013. Available at: *www.innovations.ahrq.gov/content.aspx?id=3835*

[76] Garrett N. *Hennepin Health: People.Care.Respect.* Presented at Trust For America's Health meeting. July 2013. Available at: *http://healthyamericans.org/health-issues/wp-content/uploads/2013/11/Hennepin-Health-TFAH-July-2013.ppt*

[77] Minnesota Departments of Human Services and Health. *Minnesota Accountable Health Model: Continuum of Accountability Matrix.* January 2014. Available at: *www.dhs.state.mn.us/main/groups/sim/documents/pub/dhs16_181668.pdf*

[78] Minnesota Department of Human Services. *Minnesota Accountable Health Model: State Innovation Model Grant – Draft 11/20/13.* Available at: *www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_180554*

[79] *Ibid.*

[80] Minnesota Department of Human Services. *Minnesota Accountable Health Model SIM Grant Overall Target Goals.* 2013.

[81] National Academy for State Health Policy, North Carolina, *http://nashp.org/med-home-states/North-Carolina*

[82] North Carolina Institute of Medicine. *Meeting Agenda: Task Force on Early Childhood Obesity Prevention.* 2011. Available at: *www.ncmedicaljournal.com/wp-content/uploads/2011/09/ECOP_Summary_2011-12-16.pdf*

[83] Oregon Health Authority. *Project Narrative – Oregon CMMI SIM Model Testing Application.* 2012, p.6. Available at: *www.oregon.gov/oha/OHPR/SIM/docs/Grant%20Narrative.pdf*

[84] Centers for Medicare & Medicaid Services. *Oregon Health Plan.* July 2012. Available at: *www.oregon.gov/oha/OHPB/Documents/special-terms-conditions-accountability-plan.pdf*

[85] Texas Health and Human Services Commission. *1115 Waiver Overview and Background Resources.* Available at: *www.hhsc.state.tx.us/1115-Waiver-Overview.shtml*

[86] Guariguata A, and Khalsa A. *Presentation: Texas Healthcare Transformation and Quality Improvement Program Waiver.* Oct. 2013.

[87] *Ibid.*

[88] Kirsch L. *Texas Healthcare Transformation and Quality Improvement Waiver.* Presented at the 2012 National Academy for State Health Policy Conference. Available at: *www.nashpconference.org/wp-content/uploads/2012/presentations/I.kirsch.22.waivers.pdf*

[89] Texas Health and Human Services Commission. *Regional Healthcare Partnership Planning Protocol.* RHP planning protocol. 2012. Available at: *www.hhsc.state.tx.us/1115-docs/RHP/RHP-techcorrects.pdf*

[90] Fore more information see: *http://catchusa.org/*

[91] Vermont Department of Health Access. *Vermont Blueprint for Health 2012 Annual Report.* 2013. Available at: *http://hcr.vermont.gov/sites/hcr/files/Blueprint/Blueprint%20for%20Health%202012%20Annual%20Report%20%2002_14_13_FINAL.pdf*

[92] *Ibid.*

[93] State Refor(u)m. *A Closer Look at State Innovation Model Testing Winning States: Payment and Delivery System Reform Analysis.* Available at: *www.statereforum.org/state-innovation-model-chart*

[94] Vermont Agency of Human Services. *Planning Guide to Expand Blueprint Community Health Teams with "Spoke Staffing" for Treatment of Opioid Dependence.* 2013. Available at: *http://hcr.vermont.gov/sites/hcr/files/Spoke%20Plan%20Guidance%202-12-13.pdf*

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